New Orleans Medical

and

Surgical Journal

Vol. 84 SEPTEMBER, 1931 No. 3

THE BURDEN OF SYPHILIS AND GONORRHEA IN NEW ORLEANS.*†

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NEW YORK.

Until recently statistics as to the prevalence of syphilis and gonorrhea in American communities were almost entirely lacking. Although many States require the reporting by physicians of cases of syphilis and gonorrhea which come under their care, it is a well known fact that many physicians do not report their cases, and it is only gradually that this phase of health work is improving. A procedure developed in Europe, was first used in the United States in 1926 by the American Social Hygiene Association, and later adopted by the United States Public Health Service, for learning the number of cases of syphilis and gonorrhea, by stage of disease, by color, and sex, actually under treatment in private practice and in public institutions on a given day. It was recognized that this revealed only a minimum number of cases in a given community, as a large number of individuals suffering from syphilis and gonorrhea who seek treatment from druggists and from quacks, and in addition those who entirely neglect to secure medical aid, cannot be included in these prevalence studies. From May, 1925, to February, 1929, twenty-five large and small communities in various parts of the United States had been surveyed by this method, and the population of the areas surveyed was 24,498,000, which constitute about 20 per cent of the total population in the United States. The average number of cases of syphilis and gonorrhea actually under treatment in the United States at a given time, according to these surveys, was 7.46 per thousand.

With the co-operation of the United States Public Health Service this method of investigation was applied in the course of the New Orleans Social Hygiene Survey. Very valuable assistance was given by the Orleans Parish Medical Society, and the success of our investigation into the number of cases actually under treatment in New Orleans on a given day, namely, February 2, 1931, is due in a very large degree to the co-operation of this Society, in view of the fact that without the assistance and good will of the individual physician it would not have been possible to collect the necessary data. The efficiency of the method is indicated by the fact that 99 per cent of the physicians in practice in

*Part I of the New Orleans Social Hygiene Survey made by the American Hygiene Association with the co-operation of the U. S. Public Health Service, under the auspices of the New Orleans Central Council of Social Agencies. Read before the Orleans Parish Medical Society, April 27, 1931.

†Certain sections of this report were prepared by a representative of the U. S. Public Health Service and are published by permission of the Surgeon General.

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New Orleans responded to the questionnaire with the information desired.*

According to the results of this census of cases, there were on February 2, 1931, 4,820 cases of syphilis and gonorrhea under treatment by private practitioners or in public institutions, including the hospitals, prisons, and eleemosynary institutions. This equals a rate of 12.45 per thousand which is among the highest obtained in any of the surveys made by the United States Public Health Service and the American Social Hygiene Association. Average venereal disease rates in a number of individual cities over 100,000 in size also with large colored population, may be compared with New Orleans, as follows: Norfolk, Virginia, 6.8 per thousand; Knoxville, Tennessee, 9.2; Richmond, Virginia, 9.5; St. Louis, Missouri, 15.8; Memphis, Tennessee, 19.9.

The number of cases of syphilis under treatment in New Orleans was 2,676, a rate of 6.9 per thousand. The average rate for syphilis found in the twelve studies previously mentioned was 4.1 per thousand. The rate per thousand for gonorrhea in New Orleans was 5.5, there being 2,144 cases reported under treatment. This again compares with the average rate of 3.4 per thousand in the group of studies.

Both white and colored patients show higher than average rates in New Orleans. The previous average for white patients was 7.9 per thousand, while in New Orleans it was 9.9 per thousand. The previous average rate for colored patients was 11.0 per thousand, while in New Orleans it was 19.7 per thousand. On analysis it appears that the great difference in rate per thousand between colored and white people in New Orleans is to be found in those suffering from syphilis. Thus the rate for colored males for syphilis is 16.8 as compared with 6.6 for white males. These rates for males under treatment are parallel though at a somewhat smaller figure to the rates for females under treatment for syphilis, 11.6 as compared with 2.2 per thousand white females.

Rates for gonorrhea by race are more uniform. The rate for colored males with gonorrhea is 9.6 per thousand and for white males, 8.3. For females, the rates are similar, being 2.2 for colored females, and 2.8 for white. Thus it appears that there are actually more white females under treatment for gonorrhea than colored females. These facts are well illustrated in Figure 1. This shows that in

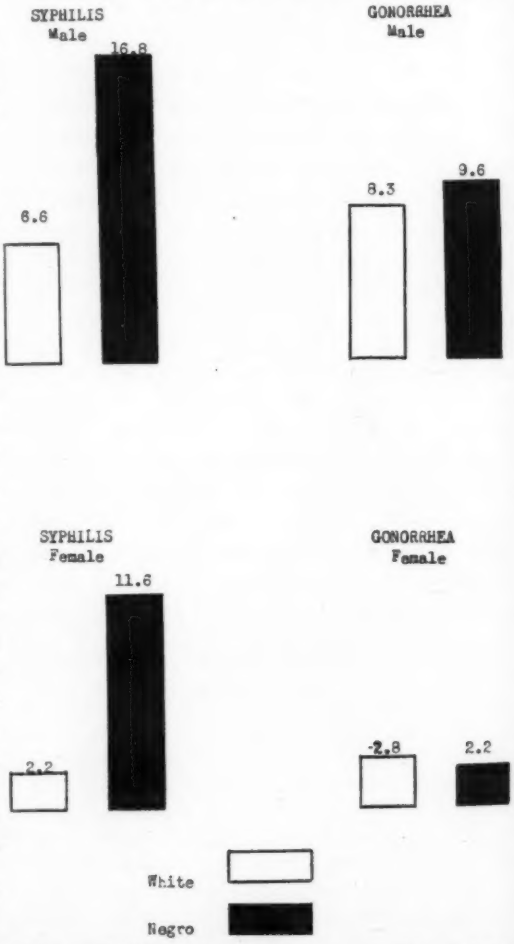

Fig. 1. Syphilis and gonorrhea rate per 100 population under treatment on Feb. 2, 1931, separated by sex and color.

*A detailed report of this census of cases will be published in due course by the United States Public Health Service. Only a preliminary summary can be given here.

New Orleans there are per thousand population more than twice as many colored males, and five times as many colored females under treatment for syphilis as there are white males and females. This, it should be borne in mind, includes not only patients who are attending clinics, but also those who are treated in private practice. It may be pointed out, however, that this is not a unique situation and that a similar state of affairs has been found in many other surveys. The high prevalence rate among the colored part of the population has been brought out with great emphasis in the course of a Wassermann survey of negroes on the cotton plantation of Mississippi where routine Wassermanns of 2,300 negroes over one year of age revealed 24 per cent positive. Studies conducted by prenatal clinics which include a routine Wassermann on all pregnant women who attend, bear out similar facts. Dr. J. R. McCord in his clinic in Atlanta found 23 per cent positive among the colored patients attending the clinic. All the evidence therefore would seem to point to a greater prevalence of syphilis among Negroes than among white people and this is evidently as true in New Orleans as it is elsewhere.

The annual incidence rate based upon the findings in the same one-day census in New Orleans during the period of January, 1931, gives the following results: For syphilis, the rate per thousand is 41 for colored males as compared with 20 for white males. The reverse of these rates is true for gonorrhea in the male, being 22 per thousand for colored as compared with 42 per thousand for white males. The colored female syphilis rate is 8 per thousand as compared with the rate for white females of 4.9, while the rate for gonorrhea in the colored female is 10.9 as compared with 13.3 for white females.

Estimates based upon these incidence rates give the following results (Table 1) as to the number of cases to be expected in the course of one year:

TABLE 1. ESTIMATED ANNUAL ATTACK RATE

	Male		Female		
	Rate	Estimated No. of Cases	Rate	Estimated No. of Cases	Total
Syphilis					
White	20	3,360	4.9	838	
Colored	41	2,255	8.0	504	
Total		5,615		1,342	6,957
Gonorrhea					
White	42	7,056	13.3	2,274	
Colored	22	1,210	10.9	687	
Total		8,266		2,961	11,227
Grand Total					18,184

It has been estimated by the New York State Health Department that it costs $200 to treat adequately one case of syphilis, and $60 to treat adequately one case of gonorrhea. Assuming that the cost of treatment of these cases would be much less in New Orleans than in New York State, we may estimate $100 as the cost for a case of syphilis and $30 for a case of gonorrhea adequately treated in New Orleans. This, according to the incidence figures given above, would give the appalling sum of $1,033,510 for the treatment of new infections alone of syphilis and gonorrhea in New Orleans in the course of one year. This does not take into account cases of longer duration still under treatment from past years, nor does this figure given in money values consider the physical suffering, the pain brought to the fami-

lies of the infected, the loss of time at labor, nor the final mortality rate, especially from syphilis.

Regarding the 4,820 cases of syphilis and gonorrhea under treatment on a given day, February 2, in New Orleans, it is important to inquire where they were treated and by whom. The returns of the prevalence study indicate that fifty-two per cent of the cases of syphilis and thirty-seven per cent of the cases of gonorrhea were under treatment in public clinics. When, however, these patients were separated by race, it is found that a far larger number of colored patients than white patients are under treatment in public clinics. The figures are as follows: Colored syphilis patients treated at public expense, 1,219 or 86 per cent—colored gonorrhea patients, 357 or 63 per cent; white syphilis patients, 450 or 36 per cent—white gonorrhea patients, 408 or 26 per cent.

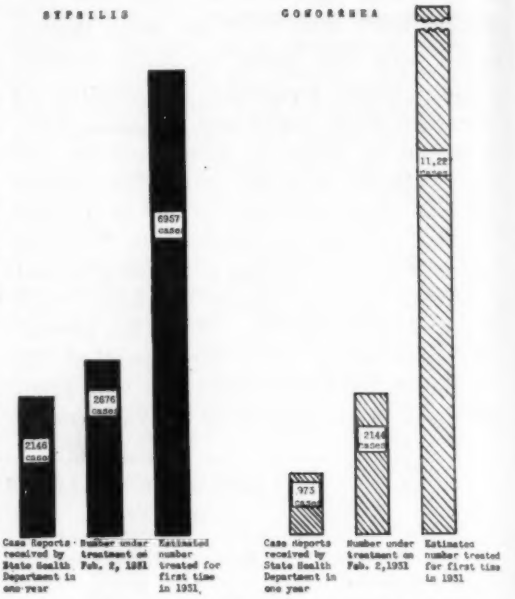
SYPHILIS
GONORRHEA
2146 cases
2676 cases
6957 cases
975 cases
2144 cases
11,22
Case reports received by State Health Department in one year
Number under treatment on Feb. 2, 1931
Estimated number treated for first time in 1931
Case reports received by State Health Department in one year
Number under treatment on Feb. 2,1931
Estimated number treated for first time in 1931

Fig. 2. New Orleans Venereal Diseasee Cases reported to State Health Department compared to data collected in prevalence study.

Assuming that the prevalence rates discovered in the course of the present study are reasonably correct, it is of interest to compare the number of newly treated cases of syphilis and gonorrhea occurring in New Orleans in the course of one year, with those reported under the law to the city and state health authorities. During the fiscal year ending 1930, there were reported to the State Board of Health, 2,436 cases of syphilis of which 2,146 were from New Orleans. Our prevalence study indicates that on one given day there were more cases of syphilis under treatment in New Orleans than were reported in the course of one whole year to the city health department, namely, 2,676 cases. During the year 1930 there were reported to the State Board of Health, 1,273 case of gonorrhea, of which 973 were from New Orleans; while there were on one given day under treatment in New Orleans, 2,144 cases of gonorrhea. Figure 2 illustrates this comparison. It will be seen, therefore, how comparatively few cases are reported in accordance with the terms of the law by institutions and physicians in New Orleans. The following figures give an indication of reports during other years:

TABLE 2. CASES REPORTED TO STATE BOARD OF HEALTH

	1928	1929	1930
Number of Cases of Syphilis	4,163	2,767	2,437
Number of Cases of Gonorrhea	2,224	1,202	1,273

These figures indicate a substantial reduction in the number of cases reported during recent years. This reduction is shown not only in figures for the State as a whole, but also for the City of New Orleans. It is suggested that the city and state health authorities should inquire into this decrease in reporting of syphilis and gonorrhea. There is no reason to suppose, so far as we have been able to discover, that there has been a decrease in the number of cases. As a matter of fact, 1929,

appears from hospital records to have been the high point in the number of cases of syphilis admitted for treatment.

The point, however, that it is desired to emphasize at this time is a comparison in the number of cases of venereal diseases, so-called, with the number of cases of other common and important diseases. Table 3 gives the number of cases reported for a number of important diseases, 1928 to 1930, Figure 3 shows a comparison between them, and syphilis and gonorrhea.

TABLE 3. CASES REPORTED TO STATE BOARD OF HEALTH, 1928-29-30.

Year	Pulmonary Tuberculosis	Measles	Pneumonia	Gonorrhea	Gonorrhea New Orleans	Syphilis State	Syphilis New Orleans	Malaria
1928	2,338	5,530	3,146	2,224	1,376	4,163	3,693	1,789
1929	2,415	1,811	3,394	1,202	876	2,767	2,436	1,495
1930	1,786	2,267	1,273	973	973	2,436	2,146	1,001
Total	6,539	9,127	8,807	4,699	3,225	9,366	8,275	4,285

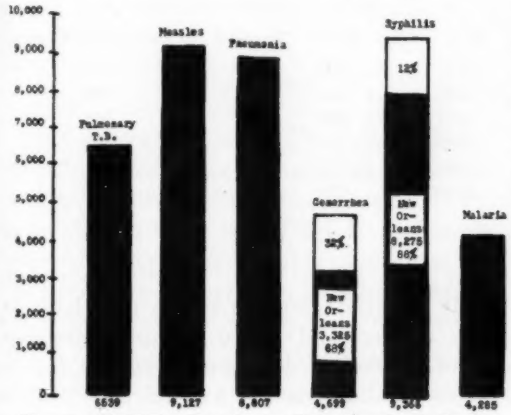

Fig. 3. Morbidity Reports to State Board of Health 1928-29-30.

Syphilis will be seen to be substantially higher than any of the other reported diseases when a three-year period is taken into consideration. The figure further indicates that 88 per cent of the cases of syphilis reported to the State Board of Health were reported from the City of New Orleans, and 69 per cent of the gonorrhea, and it is interesting to note in this connection that New Orleans includes only about 21 per cent of the population of the State as a whole.

Thus it is seen that the burden of syphilis alone is greater than any other single infectious disease in Louisiana and New Orleans, and if taken together with gonorrhea and chancroid, is even more dominantly the most important single public health question at present faced by the City of New Orleans and the State of Louisiana. Not only so, but New Orleans being the largest and most important city of the State reports a disproportionately large percentage of the total number of cases notified to the State health authorities. This is doubtless due to many factors, among which may be mentioned the fact that many patients suffering from syphilis and gonorrhea are attracted to New Orleans for competent treatment and hospitalization. Large state institutions, such as the Charity Hospital, contribute heavily to the cases reported to the State Board of Health.

Table 4. Certain Morbidity and Mortality Statistics from the Biennial Report of the Board of Health for the Parish of Orleans and the City of New Orleans (1925-1930 inclusive).

	White		Colored	
	Cases	Death	Cases	Death
Malaria	521	18	74	15
Pneumonia	2,071	1,794	2,249	2,038
Smallpox	38	——	128	2
Tuberculosis	3,349	1,994	2,582	2,046
Chancroid	698	1	530	1
Gonorrhea	4.864	6	3,576	5
Syphilis	5,018	334	12,410	717

Bearing in mind the fact that 88 per cent of the cases of syphilis reported to state boards of health are from the city of New Orleans, it is interesting to review the statistics of mortality due to syphilis during the years 1928 and 1929. Tables 4 and 5 compiled from official records give an interesting picture of the distribution of mortality due to syphilis by age and color

in recent years. In 1928 there were 500, and in 1929, 456 deaths reported to the State Board of Health. In 1929, this equalled a rate of 28 per 100,000 of the white population, and 302 per 100,000 Negro. The proportion of colored to white persons in New Orleans is about one to three. This proponderance of death due to syphilis among colored persons is of interest, but it is only in harmony with the greater incidence of syphilis among colored people as found by our prevalence study, and other investigations which have been made both among rural and city population.

Table 5. Deaths from Syphilis by Color and Age, 1928-1929.

Reported to State Board of Health.

	White		Colored	
	1928	1929	1928	1929
Under 1 year	19	12	93	83
1 year	1	3	10	6
2 years	1	0	3	2
3 years	0	0	1	2
4 years	1	0	0	0
5-9 years	0	0	1	1
10-14 "	1	0	2	6
15-19 "	1	2	16	12
20-24 "	2	2	38	29
25-29 "	3	4	39	25
30-34 "	5	7	33	15
35-39 "	2	8	28	36
40-44 "	8	12	34	35
45-49 "	14	9	31	23
50-54 "	6	13	28	34
55-59 "	7	7	17	14
60-64 "	5	4	21	8
65-69 "	3	9	14	11
70-74 "	2	3	10	4
75-79 "	3	1	3	4
80-84 "	0	0	2	4
85-89 "	0	0	0	1
90-94 "	0	0	0	0
95-99 "	0	0	0	0
100 years and over	0	0	0	0
Unknown	1	0	1	5
Total	85	96	415	360

Over the two-year period covered in Table 5, 32 per cent of all deaths from syphilis occurred in individuals under one year of age, both colored and white. The total infant mortality rate for New Orleans was 78 per thousand births in 1928, and 80 in 1929. Syphilis caused 14 per cent of all infant deaths in 1928, and 12 per cent in 1929. These are of course the infants born of syphilitic mothers and they die of congenital syphilis, a condition which is easily preventable by suitable treatment in pregnancy.

The biennial reports of the New Orleans Health Department give some interesting figures as to stillbirths in public and charitable institutions. During the period 1925 to 1930 inclusive, there were 1,706 white stillbirths and 1,216 colored stillbirths, a total of 2,922. The appended Table 6 gives the figures by years.

Table 6. Stillbirths in New Orleans. New Orleans Health Department. Mortality in Public and Charitable Institutions.

Year	White	Colored	White and Colored
1925	307	219	526
1926	310	194	504
1927	292	250	542
1928	296	257	553
1929	247	154	401
1930	254	142	396
Total	1,706	1,216	2,922

It is satisfactory to notice that both in the colored and white groups there has been a marked decrease. Syphilis is the greatest single cause of stillbirth. Professor J. Whitridge Williams, of Johns Hopkins University, makes the following statement: "Of 302 fetal and neonatal deaths resulting from 4,000 pregnancies, 34.4 per cent were due to syphilis." The reduction in the number of stillbirths is attributed to some extent at least to the better and more universal recognition and treatment of syphilis as a complication of pregnancy. The prenatal clinics at the Charity Hospital and at the Touro Infirmary, and the excellent work of the Child Welfare Association in recognizing and treating syphilis in pregnancy must have resulted in a marked reduction in the number of stillbirths due to this disease.

Unfortunately, exact figures as to the result of treatment of syphilis in pregnancy are not available in New Orleans as recent studies of the results of the excellent work of these three institutions have not been made.

Not only in New Orleans, but elsewhere throughout the United States, the reporting of deaths due to syphilis is notoriously incomplete. Yet, during the year 1928, there were in the State of Louisiana 500 deaths from syphilis, 16 from tabes dorsalis, and 56 from general paralysis of the insane. (Table 7.)

Table 7. Excerpt from Biennial Report of the Louisiana State Board of Health.

Deaths by Causes and Color, 1928-1929.

	1928			1929		
	Total	White	Colored	Total	White	Colored
Syphilis	500	85	415	456	96	360
Tabes Dorsalis	16	6	10	19	14	5
General Paralysis of the insane	56	27	29	72	23	49

During 1929, there were 456 deaths from syphilis, 19 from tabes dorsalis, and 72 from general paralysis of the insane. The above table gives a clear indication of the great preponderance of colored individuals among those who died of syphilis, including its late manifestations. These figures unfortunately say nothing about the large number of individuals who died of cardio-vascular disease due to syphilis. It is estimated that at least 15 per cent of all the deaths due to heart disease are the result of syphilis.

It is at the Charity Hospital that the largest number of cases of syphilis and gonorrhea are treated. To this great hospital as in-patients come the wrecks of untreated or inadequately treated syphilis patients occupying beds in practically every ward of the hospital. The study of the Charity Hospital report for the years 1927 to 1930 show the burden borne by that institution, due to syphilis, gonorrhea, and chancroid. The pathological reports of the hospital were studied with a view to learning how many patients were admitted to the hospital because of syphilis, and what eventually happened to these patients. During the four years under consideration, 4,776 patients having syphilis, gonorrhea, or chancroid, occupied hospital beds. These of course were in addition to the very large numbers treated as out-patients in the clinics of the hospital. As would be expected, by far the largest proportion of these were cases of syphilis, and of the cases of syphilis more than twice as many were colored patients as were white. Taking syphilis alone, we find that the results are not encouraging, as the total mortality rate for cases admitted was 77.6 per thousand cases. The case mortality rate for white patients was 86.2 per thousand and for colored patients 74.4. Table 8 gives a summary of the analysis of the records of the hospital for the four-year period under consideration:

Table 8. Charity Hospital

Number of Cases and Results of In-patient Treatment for 1927-1930.

Diseases	W.	C.	T.	W.	C.	T.	W.	C.	T.	W.	C.	T.	W.	C.	T.
Syphilis	1,067	2,365	3,451	1	1	2	560	1,370	2,030	413	718	1,131	92	176	268
Gonorrhea	606	445	1,051	20	20	40	396	327	723	212	110	322	0	1	1
Chancroid	68	206	274	0	2	2	47	148	195	21	56	77	0	0	0
Total	1,741	3,015	4,776	21	23	44	1,003	1,845	2,948	646	884	1,530	92	177	269

Syphilis Case Mortality Rate—

White	86.2	per thousand
Colored	74.4	" "
Total	77.6	" "

Bearing in mind that syphilis and gonorrhea are preventable diseases and curable when adequately treated in their early

stages, the loss of life and efficiency, the loss of time, and the cost of treatment presented by the above table, is an impressive argument for devoting more attention to the prevention of these diseases and to their early and efficacious treatment.

When the Charity Hospital was first placed in operation in 1735, it doubtless included among its earliest patients some who were there because of syphilis—patients who complained of paralysis, heart trouble, liver disease, threatened blindness or deafness, diseased joints, chronic ulcers, and other conditions due to syphilis which under various names are to be found occupying beds in all departments of general hospitals. It is appalling to think of the host of syphilitic patients who have, since its foundation, passed through the doors of this great institution. Some comprehension of the numbers may be gained from the fact that on one certain day in February, 1931, there were by actual count, 1,191 cases of syphilis under treatment by the hospital, of whom 1,011 were in the out-patient department, and 180 were in in-patient departments. In addition, there were 486 cases of gonorrhea, all but 36 of whom were being treated as out-patients. This gives us a total of 1,667 cases of syphilis and gonorrhea, who on a particular day were under treatment of the Charity Hospital. One cannot venture even a guess as to the probable number of cases of syphilis and gonococcal infections to which the hospital has ministered during the two hundred years of its existence.

According to the figures obtained in the course of the present survey there were among the total of 1,667 patients in the care of the hospital on February 2; 1,339 whose residence was given as New Orleans, the remaining 328 came from other points within the State of Louisiana, with perhaps a few from outside the state. Of the total, 432 were white, and 1,235 were colored. Thus, it is seen that colored New Orleans patients constitute 75 per cent of the burden of the Charity Hospital in caring for syphilis and gonorrhea. The details are given in the table below:

Table 9. Location of residence of patients reported under treatment or observation at Charity Hospital as of February 2, 1931

In-Patient

Residence—	Syphilis	Gonorrhea
Within New Orleans	114	13
Outside New Orleans	66	23
Total	180	36

Out-Patients

Residence—	Syphilis	Gonorrhea
Within New Orleans	818	394
Outside New Orleans	193	46
Total	1,011	440

The cost per patient per day in the Charity Hospital is at a remarkably low figure. The following table gives the cost in the out-patient and in-patient departments of the past four years:

Table 10.

Cost per patient per day—	1927	1928	1929	1930
Out-patients	$ .25	$ .22 1-3	$ .21	$ .25
In-patients	1.74	1.70	1.58	1.53

In commenting upon this remarkably low figure, the report of the Charity Hospital for 1928 made the following statement: "Certainly this is a record of which we need not be proud. That it can be done at all is due solely to the economics and stinting on necessities forced upon us in order to keep within our appropriations, which, compared with similar institutions, are appallingly small."

The costs of care at the Charity Hospital in 1930 were, for in-patients, $1.53, and for out-patients, 25c per patient per day. In 1930, there were the huge number of 37,277 visits for the treatment of syphilis, gonorrhea, and chancroid, in the out-patient department of the Charity Hospital, which, at a cost of 25c per day, would amount to $9,319. During the same year about

11,100 doses of arsphenamine were administered in the out-patient department.* It is fair to add something to the average cost per treatment as this compound is comparatively expensive. At the low estimate of 10c as a surplus to the average of 25c per patient, per day, we would have to add $1,110 to our total of $9,319, making a total of $10,429 for the treatment of venereal diseases in the out-patient department of the hospital.

Such patients as are absolutely in need of hospitalization are usually placed in the Genito-Urinary Ward of the Hospital. In this department, there are 85 beds available for genito-urinary patients, including those suffering from complications of syphilis and gonorrhea. Of these 85 beds, 42 are assigned to white patients and 43 are assigned to colored patients out of the total of 1,756 beds in the hospital.

Table 11. Work of "Genito-Urinary Clinics"

Charity Hospital.

Out-Patient Department

	1927	1928	1929	1930	Total
No. microscopic examinations	899	1,062	791		
No. patients referred to hospital	280	294	357	248	1,179
No. doses of arspenamine	9,313	11,451	11,108		
No. doses of tartar emetic	321	431	674		
No. doses of tartar emetic	321	481	674		
Total number of treatments	30,771	37,752	38,425	37,277	144,225

It is difficult to estimate the cost of the in-patient treatment of syphilis and gonorrhea, as these conditions frequently were present as a complication rather than as a primary cause of hospitalization. For the purposes of a rough estimate, we may use the hospital report figure of 978 cases of syphilis treated as in-patients in 1930. These syphilitic in-patients are assumed to have remained thirty days each in hospital. The 293 gonorrhea in-patients are assumed to have spent fifteen days in hospital. This gives us 29,340 patient days for syphilis, and 4,395 patient days for gonorrhea; a total of 33,735 patient days, which at $1.53 would cost the hospital $51,614.55.

Adding this $51,614.55 for in-patient care to the $10,429 for out-patient treatment, we have a total of $62,043 as the estimated cost of syphilis and gonorrhea to the Charity Hospital alone in the course of the year 1930.

It is well known of course that the vast majority of cases of early syphilis and acute gonorrhea can be adequately treated as out-patients, so that this is not an unusually small number of beds for the genito-urinary patients. There are but few cities that provide adequately for the hospitalization of patients suffering from syphilis or gonorrhea. The point to be emphasized here is the small cost of out-patient treatment as compared with bed treatment—in 1930 it was 25c per patient visit as compared with $1.53 per patient day. The sound policy, therefore, is so to perfect the out-patient care of indigents having syphilis or gonorrhea that they may not later become through neglect or insufficient treatment, occupants of hospital beds.

A routine Wassermann is done on practically all admissions to hospital—a very commendable practice. The work of the hospital laboratory in making Wassermann tests of blood and spinal fluid during the period 1926-30 inclusive is shown in the table following:

*The exact number of doses of arsphenamine administered in 1930 was not available at the time of the survey; hence the approximate figure for 1929 has been used in this calculation.

Table 12. Charity Hospital.
Work of the Hospital Pathology Department.
Wassermann (Blood and Spinal).

	Blood	Spinal
1926	32,398	1,243
1927	32,728	1,337
1928	29,347	1,184
1929	39,918	2,030
1930	43,211	2,026
Total	177,602	7,820

It has been estimated that in a large laboratory of a northern city the cost of performing a Wassermann blood test is about 40c. The cost of the spinal Wassermann is not less. At this cost rate the work of the Charity Hospital Laboratory in performing 43,211 blood Wassermanns and 2,026 spinal Wassermanns, a total of 45,237 in 1930, would have been $18,094.80. Perhaps the cost rate in New Orleans is less than 40c, but the total cost for performing more than 185,000 Wassermann tests in the course of five years was surely a large sum.

The Charity Hospital is free in all its departments and services; that is, it is free to the patients who are accepted for treatment, the cost of medical care being borne by the tax payers of the state and from various endowments and gifts. There are other hospitals, however, that provide "Part pay" medical care both to in-patients and out-patients, including those havings syphilis and gonorrhea. Part pay patients are those who cannot pay the full cost of medical care but who can contribute toward that cost. The Touro Infirmary conducts clinics for the treatment of syphilis and gonorrhea, called the genito-urinary (G.U.) clinics. Some of the patients are part pay patients, but most of them pay little or nothing at all.

According to figures kind'y provided by the Touro Infirmary for the Genito-Urinary clinic, there were in the six-year period 1925-30 inclusive, 4,842 patients who made 71,064 visits to the clinic. The average cost per patient visit was 77c for the year 1930. For 71,064 visits to the Genito-Urinary clinic during the six-year period, the cost to the hospital would at the 1930 rate have been $54,719.28.

Figures are available showing the amounts collected during 1929 and 1930 from patients attending the Genito-Urinary clinic for the administration of salvarsan. In 1929, the number of patients visits to the "Salvarsan Clinic" was 3,790, and from these $474.75 was collected, an average of 12c per patient visit. In 1930, the patients visit to the Salvarsan Clinic numbered 3,077, and $136.00 was collected. This gives an average of $0.04.

There are many instructive points to be noted in a study of these records. From January and February, 1929, there was a rapid fall in the average amount paid per patient visit, but the lowest average was reached in February, 1930. Again, the seasonal variation in attendance at the clinic shows the heaviest case load is carried during the spring and summer months. There are over 800 fewer patients in 1930 than in 1929. The association of these facts with the present economic depression and unemployment raises many serious questions. (Figure 4.)

A study of hospitals and clinics of New Orleans, made in 1926, under the auspices of the Central Council of Social Agencies,

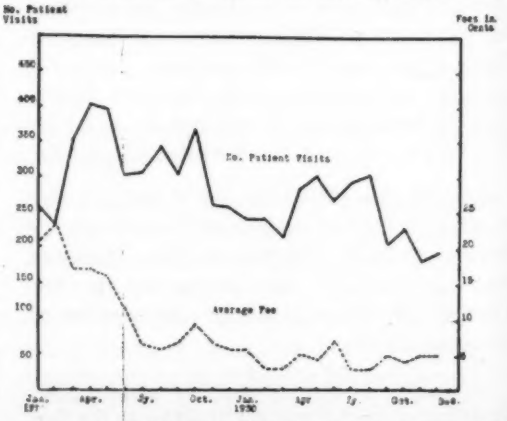

Fig. 4. Number of Patient Visits and Average Fees Collected in Salvarsan Clinic, Touro Infirmary, New Orleans, 1929 and 1930.

indicated that, as compared with other cities, New Orleans ranked high in provision of hospital care for her citizens. New Orleans ranked third in cities of similar size in the number of hospital beds per thousand population. New Orleans was fourth in the number of patients per thousand population, fifth in the number of days care. New Orleans ranked seventh in the amount per capita spent for hospitals, and sixteenth in the cost per patient day. The most interesting fact, however, was that New Orleans was first in the amount of free work done by hospitals of the city. In the hospitals of New Orleans, of the beds allocated to white patients, 57.4 per cent were free, and of the beds allocated to colored patients, 92.4 per cent were free. There were in the city's hospitals, 6.06 beds per thousand colored persons, and 6.48 per thousand white persons.

As to the clinics of New Orleans, the city stood second in per capita expense for all clinics; and first in the number of patients per capita, one out of every 2.6 persons in the city were clinic patients during a given period. New Orleans stood first also in the number of visits to clinics. It is important to notice that of these visits the ratio of colored to white was two colored to one white, while the ratio of the population was one colored to three white. On the basis of its investigation, the Committee in charge of this study of hospitals and clinics in New Orleans made the following statement:

"The Committee believes that the following conclusion is warranted: That the large amount of free hospital service and of clinic usage, which is not a proof or even a positive indication of hospital abuse (by patients who should pay), nevertheless points to a need in all hospitals for a careful study of this particular aspect of its intake problem."

The recent report of the Registration of Social Statistics of the University of Chicago, Departments of Hospitals, In-patients, Out-patients, and Dispensaries, contained some interesting references to the situation in New Orleans. In eighteen cities, with a total estimated population of 6,053,000, the number of visits to clinics and dispensaries in 1929, was approximately 2,400,000, or 396 per thousand population. A comparison of the number of visits per thousand population in 1928 and 1929 shows that the volume of service reported by New Orleans far exceeds in both years the volume of service reported by any other city. As a matter of fact, it is about three times the nearest highest rival, which is Cincinnati. In 1929, the number of visits to clinics and dispensaries per thousand in New Orleans was 1,245, whereas Cincinnati, the next highest, was 438 per thousand. This means that in New Orleans there was more than one visit per capita of population. Of the total number of visits to New Orleans clinics in 1929, 85.7 per cent were free visits, 5.7 per cent were "part-pay" visits, and 8.6 per cent were "pay" visits. The figures for certain other large cities may be compared with those of New Orleans. Thus, 71.9 per cent of visits in Detroit, and 49.0 per cent of visits in Cleveland were free visits, with correspondingly lower percentage in the categories of "pay" and "part-pay" visits.

The above facts have been introduced because it is believed that they indicate that, in the clinics and hospitals of New Orleans, far more free medical care is provided than in most American cities. Observations made in the course of the present study of clinics and hospitals seem to indicate that what is true of the general hospital and clinic situation in New Orleans is equally true for patients suffering from syphilis and gonorrhea, namely, that the proportion of free patients is unusually high. This may account for the over crowding of certain venereal clinics in New Orleans. The Charity Hospital is a free hospital supported by state funds, but the facts brought out above in regard to the Touro Infirm-

ary, a private institution supported by funds from the Community Chest and from private donors, indicate that, even in a privately supported clinic, only a small number of patients can be classified as "pay" or "part-pay" patients.

Figures are not available upon which may be based estimates for the expenditure by the small clinics for the care of patients suffering from syphilis and gonorrhea, notably the City Health Department Clinic, the Mercy Hospital Clinic, and the St. Marks Community Center Clinic. The figures estimating the cost of medical care at the Charity Hospital, and the estimate based upon the incidence rate as established in the course of our prevalence study may be sufficiently impressive to bring home to readers of this report the enormous waste suffered by New Orleans and the State of Louisiana due to syphilis and gonorrhea. Our figures do not include any estimate of the great cost for caring for victims of general paralysis of the insane, and other varieties of neuro-syphilis, who during long periods require institutional care in mental hospitals. The costs of these diseases, however, cannot be estimated in dollars and cents, but are rather to be appreciated by case studies of individual patients, and their families. To spend more money on the prevention of these diseases, and on efforts to bring infectious individuals under treatment early, and to keep them under supervision until they are at least non-infectious, would be better public health policy, more humane, and better economics, than to care for the wreckage of syphilis and gonorrhea after these diseases have done their worst, and when there are no longer possibilities of cure.

In 1905, $250,000 was spent on a campaign against yellow fever in New Orleans. Today yellow fever is practically unknown in this section of the United States. Other large sums of money have been spent for the conquest of typhoid fever, and of smallpox, with brilliant results. The public health problems presented by syphilis and gonorrhea, are in some ways more difficult, and in other ways simpler than those of the previously mentioned diseases. We have methods for preventing and for curing both syphilis and gonorrhea, but in order to deal successfully with these diseases, the medical profession and health officers must have placed in their hands adequate financial resources, and adequate personnel with which to apply the established and proved methods of control. One of the greatest American authorities on public health, Dr. Hermann Biggs, asserted that "public health is purchasable, and within certain limits, any community can determine its own death rate." New Orleans can successfully combat syphilis and gonorrhea if adequate resources are made available to the medical and health authorities of the city, many of whom are numbered among the most distinguished of the United States.

APPRAISAL OF COUNTY HEALTH WORK BASED ON REDUCTION OF MORBIDITY AND MORTALITY.*

FELIX J. UNDERWOOD, M. D.,†

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Since the avowed purpose of county health work is the reduction of the so-called preventable diseases, it is logical to conclude that a fair appraisal of the results achieved by a county health department can be secured by an examination of the morbidity and mortality prevailing in a county before and after the inauguration of this activity, as well as by a comparison with the trend in the state at large. The county health departments in the State of Mississippi have been carrrying on what may be regarded as a well-rounded program, considering their limited resources. The varied character of their programs coupled with their limitation of resources increases the difficulty of demonstrating tangible accomplishments in the prevention

*Read before the Louisiana State Medical Society, New Orleans, April 14-16, 1931.

†Mississippi State Health Officer.

of specific diseases. However, a survey of the situation led to the conclusion that an examination of our experience with typhoid fever would afford some insight into this question. This appeared likely from the circumstances that since the inauguration of these departments the State Board of health has consistently insisted that the improvement in the disposal of human excreta and the immunization of susceptible persons were the most practical means available to these departments to deal with the problem of this endemic. It, therefore, appears worthwhile to critically examine the accomplishments of these departments to ascertain whether demonstrable reduction in typhoid fever incidence has occurred which can be attributed to these activities.

This study was limited to those counties, nine in number, in which full-time health departments were organized prior to 1925, in order to have a minimal period of five years over which to study their effect. They were organized during the period 1917 to 1925. The periods for study were the three years immediately preceding organization and the five years subsequent thereto.

The counties were divided for study into two groups: Group No. 1, with less than one inoculation per person for the five-year period immediately following organization; group No. 2, with more than one inoculation per person for the five-year period immediately following organization.

The extent of privy construction is not appreciably different in either group for the five-year period following organization in each of which the data indicate that ample construction opportunities still exist.

The differences noted in typhoid fever incidence appear to be attributable to the more extensive vaccinations.

The following summary is given as a result of the study of the chart of Lee and Forrest Counties when compared with the State at large. Full-time service was inaugurated in Lee County in 1919. The average annual case rate for typhoid fever for the five years prior to organization was 41.1 per 10,000 population with an annual death rate from this disease of 3.38. The case and death rates for the State at large for the same period were 32.21 and 3.41, respectively. The average annual case and death rates for Lee County for the eleven years of full-time service were 12.1 and 1.1, respectively, while the State case and death rates during this period were 13.57 and 1.78. The Lee County case rate was reduced from 41.1 to 12.1, while the rate for the State was reduced from 32.21 to 13.57, and the Lee County death rate reduced from 3.38 to 1.1 and the State rate from 3.41 to 1.78. The explanation of this perceptible difference in reduction lies in the fact that approximately 20 per cent of the homes in Lee County were provided with safe methods of excreta disposal and the accumulated inoculations amounted to 1.87 doses per person in the county. It is confidently felt that had better results in sanitation been secured greater difference could be observed.

The verity of this statement is seen by reference to the Forrest County chart. This represents eight years before and after the establishment of full-time service. The annual case and death rates in Forrest County during eight years of part-time service were 23.95 and 3.41, respectively, while the State case and death rates for the same period were 26.35 and 2.87. Why this low endemic rate in Forrest County? During 1916, the State Board of Health waged a very successful anti-soil pollution campaign in that county. During the war, Camp Shelby was located in this county and the public health service maintained an extra cantonment sanitation station in this area. The report of the surgeon shows that 6,170 people were inoculated, but no record is given of changes in methods of excreta disposal. However, the writer knows from personal observation that the City of Hattiesburg was cleaned up in this respect.

Since its organization, the local health department has almost completely sanitated the county, more than 90 per cent of the homes having been provided with a sanitary method of excreta disposal, and has administered 1.61 doses of typhoid vaccine per person in the county. What effect, if any, has this vaccination and sanitation campaign had upon the typhoid rates? For eight years of full-time service the average annual case and death rates were 5.25 and .41, respectively, while the average annual case and death rates for the State at large for the same period were 12.44 and 1.72, respectively. This was a reduction in case rate from 23.95 to 5.25, in Forrest, as compared to a State reduction from 26.35 to 12.44 and a reduction in Forrest in death rate from 3.41 to .41, while the State death rate reduction was from 2.87 to 1.72.

In Forrest County the initiation of privy construction was not followed by a marked decline in typhoid fever incidence which became apparent only when extensive vaccination was first practiced. In most of the counties, judging from the experience in Lee and Forrest, satisfactory results in reducing typhoid fever incidence will not be secured until the inoculation rate indicates that approximately two-thirds of the population has received the complete course of three inoculations. While the experience in Lee County indicates that vaccination largely alone will materially reduce the typhoid fever incidence, the experience in Forrest County indicates that where a vaccination program is combined with sanitation a higher degree of reduction is secured.

After five years of operation many of our county health departments have not yet either sufficiently promoted vaccination or sanitation to the point where they are showing the satisfactory effect on typhoid incidence.

Complete sanitation and immunization of at least two-thirds of the population should be the minimal goal for the typhoid campaign.

In order that proper conclusions may be drawn when comparing the morbidity and mortality rates of the State as a whole with the rates of the counties included in this study, it is noted that for the period 1920 through 1929, counties which have always had a part-time health service have had approximately one-half as many inoculations per ten thousand persons as the counties included in this study.

THE AVERAGE ANNUAL CASE AND DEATH RATE PER 10,000 POPULATION, FROM TYPHOID FEVER FOR LET AND FORREST COUNTIES AS COMPARED TO THE STATE AT LARGE FOR CORRESPONDING PERIODS.

	Case Rates		Death Rates	
	Lee County	State	Lee County	State
5 years part-time service	41.1	32.21	3.38	3.41
5 years full-time service	12.1	13.57	1.1	1.78
	Forrest County	State	Forrest County	State
8 years part-time service	23.95	26.35	3.41	2.87
8 years full-time service	5.25	12.44	.41	1.72

CONCLUSIONS.

1. Effective work in disease prevention requires that activities of county health departments be largely limited to measures of proven value in the control of specific diseases.

2. The most tangible results of county health work are manifested in the reduction of the incidence of specific diseases occurring as a sequel to the effective application of specific measures.

3. This trend can be satisfactorily demonstrated only when satisfactory and adequate records are kept by the county health organizations.

4. When these records fail to show an adequate reduction in disease incidence, after a reasonable length of time, it may be inferred that the activities of the local

health departments are insufficient to deal with the situation and are ample justification for the intervention of the central organization.

5. A typhoid fever vaccination rate of two-thirds of the population will show a marked reduction in the morbidity and mortality from typhoid fever.

6. A typhoid fever vaccination rate of two-thirds of the population and a sanitary privy rate of 95 per cent of homes will reduce the rate more than vaccine alone.

DISCUSSION.

Dr. J. George Dempsey (New Orleans): It is a pleasure to have this opportunity of opening discussion on the paper entitled: "Appraisal of County Health Work Based on Reduction of Morbidity and Mortality" by Dr. Felix J. Underwood, State Health Officer for Mississippi.

So long has he been actively identified with health work in Mississippi that I dare say Dr. Underwood's name is as well known in his native state as that of Bilbo or Harrison. Having been a constant visitor to Mississippi myself for the past forty years, I can appreciate all the more the decided advancement in health matters that has been made in that state under the skillful leadership of Dr. Underwood.

The opening paragraph of Dr. Underwood's paper states with commendable terseness the avowed purpose of county health work is, "the reduction of the so-called preventable diseases." Upon first reading this statement the thought struck me that it would be interesting to canvass our own state of Louisiana and find out just how many people realized what is the purpose of our parish health work. The fact that it is solely for the purpose of protecting the health of the people, might quicken in those people themselves that spirit of co-operation which is such a dire necessity for the attainment of the best results.

Dr. Underwood has shown just what county health work is worth. While this appraisal is founded only on morbidity and mortality for typhoid fever in a county before and after the inauguration of county health work, the statistics he gives nevertheless do afford an insight into the practical value of county health work.

The following figures and percentages are the results of the tabulation in the Vital Statistics Department of the Louisiana State Board of Health:

Year	Reported Cases	Reported Deaths	Death Rate Per 100,000	Health Unit Complete Typhoid Immunization	Directors of Health Units
1921	1033	325	17.8	6915	6
1922	1085	323	17.6	.....	6
1923	922	265	14.3	.....	6
1924	1252	410	21.9	19593	9
1925	2318	639	34.0	34306	11
1926	1187	333	17.3	9618	10
1927	1066	283	14.6	98196	21
1928	1049	262	13.4	48026	29
1929	825	221	11.2	83282	31
1930	1145	247	11.7	124337	31

In Louisiana the figures on malaria fever may also serve the same purpose. I regret that I have had only a brief few minutes in which to prepare for this discussion, otherwise I would have had tabulated a more elaborate set of figures to demonstrate this point. However I am pleased to quote the morbidity and mortality statistics on malaria fever in Louisiana for the past three years:

	Deaths	Death Rate per 100,000 population	Decrease
1928	251	12.7	.....
1929	206	10.4	2.3
1930	178	8.4	2
Total decrease in 1930 over 3-year period			4.3

While it cannot be said that parish health boards and units are entirely responsible for this creditable showing, it is quite evident that they have been dominant factors in making possible such a decided decrease in the death rate from this one disease alone. In parish health organization, such as sponsored by the State Board of Health and the Louisiana State Medical Society, rests the secret of the prevention of disease; and one can scarcely help agreeing with Dr. Underwood that in county health work lies the secret of the prevention of disease.

Certainly the Drought Fund voted by Congress and allocating $200,000 to each state affected and the millions to be spent throughout the United States for the White House Conference on Child Health and Protection, will augment parish health work as it at present exists in Mississippi and Louisiana.

Dr. Underwood (closing): The reduction of morbidity and mortality is the yardstick of public health work and the only measure by which we may know that we are obtaining good results from our program.

I wish to thank Dr. Dempsey for his discussion of the paper and for the very nice things said about the public health program of Mississippi and the executive officer of the Mississippi State Board of Health.

SOME OF THE PROBLEMS CHALLENGING THE DOCTORS AND HEALTH OFFICERS IN MISSISSIPPI.*

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MERIDIAN, MISS.

In undertaking this discussion it appears in order to set forth as clearly as possible the aims of the practitioner and the health officer. An accepted definition applying to the practitioner has been laid down as being, "for the relief of pain; restoration of the body from sickness; the prevention of disease; the promotion of health; and an ultimate extension of the life span." The aims of the health officer has been stated as, "for the prevention of disease; promotion of health, and extension of the life span." From these definitions it appears that public health is a special field rightly placed in the medical profession. It is likewise apparent that the practitioner, if he embodies in his activities a well-rounded program, should give equal thought to preventive measures. Hippocrates, the author of the oldest medical treatise in existence, the father of medicine, whom all doctors honor and revere, in specifying the duties of medical men, placed equal importance on the preservation of health and the curing of disease. No physician trained in the principles of his profession ignores the preventive side of his activities. The purpose of this rather vague preamble is to impress on our minds that the practitioner and health officer are to a great extent on common ground.

Repeated surveys and a look at the morbidity reports and death certificates as they come in from time to time from over the state disclose that a few causes are responsible for the great majority of ailments and deaths among the young. Closely interwoven, united effort on the part of the profession would tend to reduce diseases and cut down death rates among our younger groups in a short time.

In surveys conducted in various parts of the state, it appears that approximately 34 per cent of the colored population more than fifteen years of age, and slightly less than 5 per cent of the whites in the same age group have a positive Wassermann blood reaction. If this be correct, there are on the basis of the last census 275,000 persons now suffering from syphilis in this state. Estimates may go wrong; let us be conservative and assume that we have only half that number, or 137,500. (The most skeptical should not doubt the existence of this number.) It is estimated conservatively that at least 33 per cent, or about 45,000 of these patients, are unable to pay for treatment. The practicing physicians can not afford to give their time and buy medicine for these cases without hope of a return on their investment. It is not within the scope of the County Health Officer's duties to do such work, and so he does not wish to treat them. These people are a hopeless lot confronting us. Does this not appear to constitute one of the problems confronting the profession, and should it not be met by some means through the various medical groups, state and community hospitals? There is a consciousness on the part of the profession of the tremendousness of such a problem in this state at this time as has never before existed.

Another health problem that exists in certain sections of the state, especially in the hill and coastal plain sections, as is evidenced by surveys made at different times, is the existence of intestinal parasites. In some communities the infestation in school groups exceeds 60 per cent. This, it seems, is not alone a public health problem, but constitutes one of the major

*Chairman's Address. Read before the Section on Hygiene and Public Health at the Sixty-fourth Annual Session of the Mississippi State Medical Association, Jackson, May 13, 1931.

problems confronting the entire profession. Every school child and many in other groups in these infested areas should be examined at least once a year and if found to have the disease, should be treated until cured. Sanitation of the home and school should receive proper consideration with regard to excreta disposal where the disease prevails.

The 1930 morbidity reports for the state registered a total of 50,477 cases of malaria. This is probably not exaggerated. Some cases may have been reported as malaria that were not, but many cases were not reported, never coming under a physician's care during their illness, thus making the total in the neighborhood of the number reported. A proper approach toward the solution of this problem is being made in the practice by many physicians of making a blood examination of all malaria suspects. When this method is universally followed, the foci of malaria may be fairly definitely charted and means applied for its prevention. Close work between practitioner, laboratory technician, and health officer will be required. It appears that progress in greatly reducing this disease is about to be made through the earnest efforts of Dr. Mark F. Boyd.

During 1929 there were 3510 cases of tuberculosis registered from morbidity reports of practitioners in the state. This without doubt is incomplete. It is claimed by some epidemiologists that there are ten active cases of tuberculosis in a community for every death occurring therein. If this be true, there were about 16,500 cases that year, as 1649 deaths were registered.

Lack of care of mothers during the prenatal, lying-in, and postnatal periods is reflected in a total of 584 deaths from causes connected with these states registered in 1929. Of this number, 326, or about 56 per cent, were white. This is food for thought. Likewise, a total of 929 deaths recorded of children in early infancy in that year reflects a condition not met in the manner desired. Of this number, 577 were white, approximately 62 per cent; likewise, food for thought.

More than 30 per cent of the men examined during the World War were rejected either by local boards or after they reached camp because of physical unfitness. It is common knowledge, gained from reports of physical examinations of school children and yearly health examinations made by industries and insurance companies of other groups, that a large majority of both children and adults are in possession of one or more physical defects which interfere with their efficiency and well being. A glance at mortuary statistics reflects the grim story that too many young people are dying.

For some time there has been a movement urging a careful physical examination of all persons at yearly intervals with correction of defects that may be found. From this movement fruit is being borne in a gradual extension of the average life span as well as improvement in the sturdiness of the citizenry. This program, without doubt, will yield more far reaching benefits if intensified and carried to a larger number of people. The practitioner is doing a higher type of professional service as a result of this phase of his activities. Some doctors give special attention to the yearly physical examination and correction of defects, and "call up" their clientele, reminding them that only a year ago they were up for examination and that it is time for this to be done again. With such an arrangement the family doctor is able to keep his hands and eyes and mind on the physical progress of his people, and could do the immunizations against typhoid fever, smallpox, diphtheria, and other perventive work that he of right should do. (There were 1315 cases of typhoid, 810 under 20 years of age, highest incidence in July, and 1786 of diphtheria, 1443 in children under ten and highest incidence in August, reported

in 1929 with 197 and 162 deaths, respectively, from these causes.)

The condition set forth in the preceding paragraphs constitute in the mind of the writer some of the major problems confronting the medical profession in this state. The challenge: if these problems are to be met in the manner calculated to yield greatest results, the services of physicians, health officers, dentists, and nurses, with adequate training in their respective fields, together with hospitals carrying modern diagnostic and therapeutic equipment, should be in easy reach of every community.

THE ROLE OF THE GENERAL PRACTITIONER IN MODERN MEDICINE.*

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The progress of medicine for the last fifty years has been as swift as the eagle's flight. No one man has been able to keep step with it all. Much that was mysticism and guess work has been replaced by scientific discoveries. The last half century has been really the era of curative medicine. Now we are at the sunrise of a new day, that of preventive medicine and preventive surgery. Requirements for graduation in medicine have been raised time and again and the cost multiplied over and over. Specialties have been magnified by the medical schools until the profession has become top-heavy with specialists. The cities are crowded to the utmost limit with doctors, while the rural communities are starving for the benefits of modern medicine. Generally speaking, the specialist is underworked and overpaid, while the general practitioner is overworked and paid barely enough to keep soul and body together.

Heart disease heads the list for human casualties caused by illness. Prevention is the treatment of choice, and this must be done largely by the family physician. Cancer is another unconquered enemy that is successfully defying the medical profession, and ranks next in its toll of human life. Here the general practitioner must be aroused to the importance of early diagnosis. He must have the facilities and the time to make the examinations, and his observations must be recorded, if we are to master this disease. And great is the field of preventive surgery, especially as it relates to good obstetrics. Here the public depends largely upon the general man for more efficient service in a great and open field. Even yet the majority of people become ill and die of the common, ordinary, every-day diseases and we cannot overestimate the vigilance and efficiency of the general practitioner. Preventive surgery and preventive medicine are the eastern star that beckons us to higher and nobler attainments in the service of our profession and offers the greatest returns socially and economically to us and to our clientele. Preventive medicine is not the work of the public health officer alone; its challenge reaches to every practitioner. Social ethics and better eugenics constitute a field with multiplied opportunities open to the medical profession where the advice of the general practitioner is of the greatest value.

The influential leaders in medical thought have underestimated the value and the importance of the general practitioner. But, say what you will and think what you may, he is the corner stone of the profession. There has been a tendency to discard as "obsolete" the man who has been in practice for twenty-five years. It is true that there is much that he does not know in laboratory diagnosis, intravenous therapy and some of the latest anesthesias. But he has a basis, he has the foundation upon which the newer knowledge can be built easily. He knows the clinical symptoms

*Chairman's Address. Read before the Section on Medicine at the Sixty-fourth Annual Session of the Mississippi State Medical Association, Jackson, May 12, 1931.

from experience, if not from study. He has a working knowledge of the human organism, how it reacts against disease, and how it behaves under stress and strain; he has learned in the school of experience. It is true that there must be some adjustments to aid the practitioner and to enable him to better serve the public.

The general practitioner in medicine or surgery should be just as much a specialist in his line of work, within its limits, as the eye, nose and throat men. His scope of work requires him to be more broadly educated and more versatile in general than the average specialist. The medical school should put in a course especially suited to the needs of the man who does general practice, the man who has been in practice for several years, as well as for the student who is beginning his course in medicine. The short cut to a medical diploma to supply physicians to the rural communities will not work. It is foolish to think of lowering the standards or taking short cuts. Deans of medical schools must be more careful in selecting their students. Scholarship is good and of great importance, but a professional mind, a medical soul, and a missionary heart are of still greater importance. Never has the challenge been so gigantic, nor the opportunities so great as at this time.

The general practitioner of medicine and surgery is the backbone of the profession, but he must have special training in his field, technical training for the treatment he is to administer, and native endowment in addition to this training, to enable him to administer his clearing house duties as he should. The general man must be able to tell when a real specialist is needed in the case. He must be big enough of heart to turn the case over cheerfully when this is evident. He must have ability to put all the facts and findings together and to interpret them in their proper relations to a diseased body and a mind disturbed socially and economically. The practitioner must also study to prove himself a good business man.

To bring modern medicine to the masses at a cost at which they may utilize it is our greatest social and economical problem. We must make our profit on volume of business rather than a high price to the individual. In order to do this, the patient must come to the practitioner. In a well-ordered clinic or a small hospital he can see a dozen times as many patients perhaps, he can have trained help, the patient will come before he is gravely ill. It is better for a dollar-a-day man to spend his time on the road than it is for a man who has spent $10,000 and ten years of hard work preparing to practice medicine. It is impossible now to apply modern medicine in many instances out in the homes of the rural community. Hence, our greatest means in enabling the practitioner to serve his clientele better and at less cost is the community hospital and the well-ordered clinic. If our State will take care of the actual charity in the territory of the small hospital, it can live and serve. The community hospital will encourage co-operative medicine, promote preventive medicine and the yearly examination and act as a post-graduate school for the medical profession. In this way the standard of efficiency of the general man might be raised to a much higher degree and at the same time bring modern medicine to the rural community at a reasonable cost. It is time for the man out at the cross roads and down by the mill to have some consideration at the hands of his State. He has been paying taxes all these years. A charity hospital 200 miles away is no good to him. He needs and must have the service in his own or adjoining county. It is time to "render unto Caesar the things that are Caesar's." It is time to do honor to the general practitioner and to remunerate him commensurate with the service he is rendering.

In the meantime, let us keep up the morale. Let us not be weary during this transitional period from an already great

to a still greater service. You have, you are, you will meet the demands. Your reward must come. As long as matter goes undestroyed service must be paid for in some form. Let us raise the standard as high as we can under the circumstances. Let us be efficient to the limit of our ability. Let us diagnose and treat the common everyday diseases in the very best way we can. Let us not count anyone thing common or of minor importance in this great profession of ours. Let us meet the challenge of a needy people. Let us carry on with dignity and pride and perseverance. The general practitioner is the corner stone of the greatest profession on earth. In the words of the poet, "Let us walk with the man in the road" and "Let us keep on keepin' on." Let us keep in mind the words of Walter Gresham and also heed the words of the unknown poet.

LET ME WALK WITH THE MEN IN THE ROAD.

'Tis only a half truth the poet has sung
  Of the "house by the side of the way";
Our Master had neither a house nor a home,
  But He walked with the crowd by day.
And I think, when I read of the poet's desire,
  That a house by the road would be good;
But service is found in its tenderest form
  When we walk with the crowd in the road.

So I say, let me walk with the men in the road,
  Let me seek out the burdens that crush,
Let me speak a kind word of good cheer to the weak
  Who are falling behind in the rush.
There are wounds to be healed, there are breaks we must mend,
  There's a cup of cold water to give;
And the man in the road by the side of his friend
  Is the man who has learned to live.

Then tell me no more of the house by the road.
  There is only one place I can live—
It's there with the men who are toiling along,
  Who are needing the cheer I can give.
It is pleasant to live in the house by the way
  And be a friend, as the poet has said;
But the Master is bidding us, "Bear ye their load,
  For your rest waiteth yonder ahead."

I could not remain in the house by the road
  And watch as the toilers go on,
Their faces beclouded with pain and with sin,
  So burdened, their strength nearly gone.
I'll go to their side, I'll speak in good cheer,
  I'll help them to carry their load;
And I'll smile at the man in the house by the way,
  As I walk with the crowd in the road.

Out there in the road that goes by the house,
  Where the poet is singing his song,
I'll walk and I'll work midst the heat of the day,
  And I'll help falling brothers along—
Too busy to live in the house by the way,
  Too happy for such an abode.
And my heart sings its praise to the Master of all,
  Who is helping me serve in the road.

—Walter J. Gresham.

KEEP ON KEEPIN' ON.

If the day looks kinder gloomy,
  An' the chances kinder slim;
If the situations puzzlin'
  An' the prospects awful grim,

An' perplexities keep pressin'
  Till all hope is nearly gone—
Jest bristle up and grit yer teeth
  An' keep on keepin' on!

CHAULMOOGRA OIL IN THE TREATMENT OF ARTHRITIS.

A PRELIMINARY REPORT.*

PAUL A. McILHENNY, M. D.,†

NEW ORLEANS.

In 1926[1] I announced the observation that the secondary infectuous type of arthritis is not encountered in leprosy. Occupying the position of Orthopedic Consultant on the staff of the U. S. Marine Hospital, No. 66, the National Leprasarium at Carville, Louisiana, for a number of years I have been able to observe these cases, and the fact was so impressed upon me that I sought for some reason to explain why these unfortunates did not develop such conditions. I then arrived at the conclusion that, since leprosy is attended with rather marked metabolic disturbances, the disease itself could not be preventing an

*Read before the Orleans Parish Medical Society, New Orleans, June 22, 1931.

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arthritis, and I then conceived the theory that possibly the treatment of leprosy might be the reason. I consulted with my associates on the staff of the hospital, and with visiting physicians connected with other leprasaria, and without exception my observation was sustained in that none of these gentlemen could recall having seen arthritis of the types considered in lepers. After two more years of investigating I concluded that chaulmoogra oil was responsible for the prevention of this widespread disease.

It is an established fact that, in the test tube, chaulmoogra oil has powerful bacteriacidal properties;[2] it is also an established fact that it has no deleterious effect on any organ of the body when given in medicinal doses; it does, however, produce gastric irritation when given in large doses by mouth, and a local myositis when excessive amounts are injected intramuscularly. With these facts in mind I determined to try this drug in the treatment of the atrophic, hypertrophic and the mixed, combined or altro-hypertrophic types of arthritis. No other types of arthritis have been treated with it, nor will any other be considered in this announcement. The method used consists of bi-weekly intramuscular injections of from 3 to 5 c.c. of the crude oil, and from 0.3-1.6 c.c. in enteric capsules by mouth at meal times. The formula for the injection material is that of Dr. F. A. Johansen, of the National Leprasarium at Carville,[3] and consists of 0.2 gm. of benzocaine, 10 c.c. of olive oil, and 90 c.c. of crude oil. Twenty-four to forty-eight hours are required for the preparation of this formula. The regions selected for injections are the deltoid and buttock. Five c.c. may be injected into the deltoid alternating with 8 c.c. into the buttock. Five c.c. is the amount generally used both in the deltoid and buttock though a larger amount may be injected if the patient's tolerance allows; the mixture is given at body temperature. After injection a slight local reaction producing moderate pain is experienced but this passes off within 24 to 48 hours when the oil has been completely absorbed. The injection is best made through a two-inch spinal needle, and care should be exercised that the oil is not injected into the fascial planes or periosteum as a sterile abscess may develop if these areas are invaded.

The use of the drug by me in the treatment of arthritis is purely empirical, and no attempt will be made at this time to explain why it is beneficial in arthritic cases. Mention might be made of the active principles which are two, namely, hydrocarpic acid and chaulmoogic acid, these are unsaturated acids,[4] also that chaulmoogra oil stimulates leucocytosis.[5] Urinalysis shows acetone but this is believed to be a split up acid rather than true acetone.

The use of the drug for the treatment of arthritis was first started by me in February of 1930, and up to the present 39 patients have been discharged from the hospital; 29 of these were from my own service, and 10 from other services. All of the patients were in bad condition demanding hospitalization and most of them were confined to bed. No selection of cases was made other than that they were of the atophic, hyperthrophic, or the mixed type and diagnosis was confirmed in most cases by roentgen-ray. All foci of infection were investigated and cleared upon when possible especially chronic constipation. No attention was paid to special diet. Without exception every patient has shown improvement; many complete relief of symptoms, and restoration of function; others arrestment of the disease and reduction of deformity. No patient has been readmitted to the hospital with a return of the condition. Thirty-nine patients have been discharged, and at present there are nine being treated in my service alone, and all are improving. The procedure is therefore offered as the one method that has given me better results in the treatment of these conditions than all others.

Improvement may be expected during the second week of treatment; the average patient becomes symptom free in about eight weeks.

The following cases were of the advanced type and are therefore cited:

CASE REPORTS.

Case 1. Mrs. R. H., white, aged 40 years, admitted June 16, 1930, with combined or mixed type. Five years previous she began having pains in hands, knees, and ankles, later her shoulders, elbows and wrists became involved. When admitted she complained of pains in fingers and wrists, elbows, shoulders and knees, with increased fluid in wrists and knees; fingers showed fusiform enlargement, knees were flexed. Had been treated with various anti-arthritic measures before coming to hospital, but had experienced no relief. Questionable teeth and tonsils had been removed; constipated. Roentgenogram showed atrophic and hypertrophic arthritis. She was given bi-weekly intramuscular injections of 5 c.c. and 1.6 c.c. by mouth t.i.d. of chaulmoogra oil. Discharged on December 17, 1930 symptom free.

Case 2. Mrs. M. J., white, aged 33 years, admitted February 8, 1931, with atrophic type. Hands and fingers swoolen and tender, fingers showed ulnar deviation; interossei and lumbrical atrophy; ankles, knees, elbows and shoulders also involved. Teeth had been removed; tonsils negative; constipated. Was treated with chaulmoogra oil. Discharged May 13, 1931, symptom free.

Case 3. E. S., colored male, aged 38 years. Porter. Admitted November 21, 1930. Diagnosis, atrophic arthritis, chronic myocarditis. Complained of pain and stiffness in all joints. Similar attack three years previous to present illness. Examination showed swelling and pain in fingers, wrists, elbows, ankles and knees, shoulders and hips also involved; knees and fingers flexed; could not flex or extend fingers; no edema, Wassermann negative. Constipated. Treatment: Bi-weekly injections, as well as by mouth. Discharged February 12, 1931, with normal motions and no pain. Is back at work.

Case 4. J. R., white, male, aged 45 years, admitted February 27, 1931, with hypertrophic arthritis of lumbo-sacral, sacro-iliac and hand and wrist. Constipated; teeth and tonsils had already had attention; had had pain in back and left leg for four years; unable to extend leg or bend over, forced to lie on his side. Wassermann negative. Was treated with iodo-cincophen for five weeks without relief. After five injections of chaulmoogra oil and 1.6 c.c. t.i.d. by mouth he was able to be up, walking around. Was discharged May 20, 1931, free of pain, and with almost normal motions; returned to work.

Case 5. Miss R. S., white, aged 29 years, admitted January 9, 1930, with advanced atrophic arthritis. Fingers, hands, elbows, shoulders, jaws, hips, knees, ankles and toes involved; fingers and toes showed flexion contraction; fibro-chondromata on dorsum of meta-carpal, and under elbow joints. Had been in my service for the same condition previously, and treated with amiodoxyl, benzoate, iodo-cincophen, guaiacol carbonate and activin without relief; teeth and tonsils had been removed. Was put on chaulmoogra oil February 4, 1930, and still under treatment. This is the most persistent case in this series. She has improved remarkedly, and from being unable to walk or use her hands or arms she is now up and about with no pain except when walking, when she has some discomfort in her ankles, this is thought to be due to the marked deformity of her ankles and feet rather than to the disease. The condromata have reduced in size and are not sensative; all points are normal and size and appearance except the fingers and toes. Continued improvement and final arrestment is expected in this case.

I am rather inclined to the opinion that treatment should be continued for some weeks after patients have become symptom free.

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DISCUSSION.

Dr. E. D. Fenner (New Orleans): I regret that, in opening the discussion, I am not able to bring any very positive testimony as to the efficacy of this newest specific for chronic arthritis. My personal experience in the use of chaulmoogra oil began only a few weeks ago, and the number of cases upon whom I have been able to apply it is a small one. None of them, moreover, have been under treatment long enough to either confirm the experiences related to the essayist, or to negate them.

I confess that I am not quite so optimistic in regard to the results to be expected from the treatment of chronic atrophic, hypertrophic, and

mixed arthritis with chaulmoogra oil, as the essayist probably is. It is a universal experience that tthe inventor of an operation, or the discoverer of a cure, is likely to report better results than his colleagues do. Chronic arthritis has had more cures discovered for it than any other disease in the world, but most of them have been discarded, while chronic arthritis continues to torment and cripple thousands. A final verdict upon the value of chaulmoogra oil as a cure for chronic arthritis must, therefore, await a wider experience. But whether other men find it as efficacious as Dr. McIlhenny has or not, this is an exceedingly interesting contribution, because any one who discovers a remedy that will benefit even a fourth of the cases of chronic arthritis will have done a great deal for suffering humanity.

I congratulate the essayist upon his original investigation, and I sincerely hope that experience will lead me and many others to a like confidence in its curative power.

Dr. Youman (New Orleans): I have not had much experience in the treatment of arthritis with chaulmoogra oil except for a few cases while on an orthopedic service.

There were two cases of particular interest. One of the cases had bilateral hydrarthrosis on whom we had tried most of the accepted methods of treatment of arthritis, without result. I had heard Dr. McIlhenny praising chaulmoogra oil and decided to try it. I gave it to the patient as Dr. McIlhenny has outlined and, after six weeks of treatment, we sent him out of the hospital symptom free. I have followed his case up and he has remained symptom free since. The second case was a white female sixty-five years old who had been in the hospital for six months. We had been treating her by different methods without result, so we used chaulmoogra oil on her and after eight weeks of treatment sent her home. I have not been able to follow this case up so I don't know if the symptoms have returned or not.

Dr. Isbel (New Orleans): I have been fortunate enough to work with Dr. McIlhenny for two months on his service. During that time we had about eleven cases we were treating. We were unable to obtain the chaulmoogra oil for about a period of ten days. During that time the patients could not receive their injections. There were two which had the hypertrophic type with a great deal of fluid in the joints and edema about the joints. During the period in which there was no chaulmoogra oil, they developed increased swelling and edema about the joints with increased pain, which was not reduced by salycilate or iodo-cincophen. When we got the new supply of chaulmoogra oil and were able to continue injections, the swelling went back to the point to which we had reduced it before the chaulmoogra oil gave out, and the symptoms receded.

We had another case who came in with minimum amount of disability, a patient we were unable to keep in the hospital. He remained in the city about seven weeks to get his chaulmoogra oil, coming to our orthopedic clinic to get his injections twice a week. When he left, after six weeks, he was able to use his hands and go back to work.

Dr. Davis (New Orleans): When I took over Dr. McIlhenny's orthopedic service at Charity Hospital as his interne, I had heard a lot about oxyl-iodide compound and how good it was in the treatment of certain types of arthritis. A case of hypertrophic arthritis of the lower lumbar spines was admitted to the service, so I immediately put him on this preparation. When Dr. McIlhenny saw the case, he allowed me to continue the same treatment. After five weeks of extensive iodo-cincophin therapy, and a lot of persuasion toward improvement on my part, the patient was very little better, if any.

He was then put on the usual chaulmoogra oil treatment and I'll have to admit that, after two weeks of this, he showed definite signs of improvement.

I handled with Dr. McIlhenny two of the most serious cases he has mentioned and I might say that, had it not been for a definite set-back due to vaccinia from smallpox vaccination on the part of one, she would have improved more steadily. The treatment was discontinued at this time.

Throughout the whole service, I saw more of the cases than Dr. McIlhenny did, and I think I noticed even more improvement in the patients than he did, so I am ready to vouch for everything he has said.

Dr. Moseley (New Orleans): I am interested in chaulmoogra oil. I am interested in it not because I am working with it, or have any immediate knowledge of it, but because of the contribution it seems to have made to medical science.

From my casual reading of Roger Adams' work on the determination of what might be called the active principles of chaulmoogra oil, I am rather interested to know whether the drug as reported by Dr. McIlhenny is the original chaulmoogra oil, or if it may be one of the newer synthesized drugs emanating from the researches of Roger Adams of the University of Illinois; whether the oil you have used has been purified from all unnecessary and inert, though sometimes active, impurities, or whether it is the newly synthesized product which you have found ex-

tremely efficacious in the treatments described? Thank you.

Dr. Edith Loeber Ballard (New Orleans): Just recently I came across two cases of arthiritis deformans. One was a man who had been incapacitated for twenty-five years, and the other, a boy nineteen years of age, just starting with the disease, showing what seems to be an hereditary tendency. Is it possible to send these two cases to Dr. McIlhenny for assistance and some further treatment? If you would like them, you may have them.

Dr. Boudreau (New Orleans): I was on Dr. McIlhenny's service also for two months during which time eight cases were treated by the method discussed. Four of them were cases that were already being treated when I came on the service, and the other four I started treatment on. These last four were discharged, two at the end of four weeks and two at the end of six weeks. They were all much improved and able to carry on their work. The other four cases were far advanced arthritis but showed some improvement during the two months of treatment.

Dr. Joachim (New Orleans): I feel very much like a liason doctor, bringing before this body a message on chaulmoogra oil.

At a recent meeting of the ear, nose and throat association, one of our prominent eye doctors assured us that chaulmoogra oil, sprayed in the nose, was of benefit in eye and nasal pathologic conditions of chronic inflammatory nature. This is of great importance if based on accurate observation.

Chaulmoogra oil in these conditions is recommended to be used in dilution with oil derived from the sunflower seed.

Chaulmoogra oil is coming into greater use than ever before and, if these reports turn out to be based on facts, it will be an important addition to our therapeutic resources.

Dr. T. J. Dimitry (New Orleans): It was I who read the paper on the effect of chaulmoogra oil in eye and nose conditions at the Eye, Ear, Nose and Throat Club some months back, as recited by the doctor who has just spoken.

I have been very much interested in this therapeutic agent and I have been hunting for an explanation of its beneficial effect. My whole work is still experimental and my contribution merely recited facts.

I compliment Dr. McIlhenny in his work and I feel certain that he is accomplishing a good in the condition recited. I feel that before very long the "why" will be explained, but we must be watchful in reciting the many beneficial effects and control rigidly any statements. The latter is the reason for my delay in publishing more upon the subject.

Dr. Webb (New Orleans): It would be futile on my part to attempt to add anything to what Dr. McIlhenny has said, but I am on his service at the present time and have been associated with him for six weeks. We have treated sixteen patients since I have been associated with Dr. McIlhenny and four of these patients remain in the hospital now.

There are some who are coming from Lockport and Thibodaux and other towns over the state who have been materially benefited and so much so that they come regularly twice a week for their injections. They have both the hypertrophic and atrophic type. Some could hardly walk when they came in. All of them have been materially benefited. However, some of the results are not very good but we see some improvement.

One thing has not been brought out. You have to be very careful in giving these injections because you sometimes get abscesses. We have had a few of these. It seems to be very irritating, probably due to the fault of the man gives it and probably due to the olive oil that we have used that was not the purest type. I find most of the cases are greatly benefited with chaulmoogra oil.

Dr. DeMotte (New Orleans): We are using the chaulmoogra oil treatment in the clinic as well as on the wards. Patients, of necessity, have to be taken out of the hospital before they are cured, and sent to the clinics over a long period of time, and we find we can use the chaulmoogra oil there and adequately follow up the cases. We have been using it for the past month and of the few cases that have come into our service, there are two which have shown very definite improvement. These two were on salicylates, but were taken off the latter and chaulmoogra oil used alone intramuscularly and orally.

Two arthritis cases in the hospital in our service seem to have presented more or less of a therapeutic problem, both of the hypertrophic type. One had salicylates on the outside and salicylates in the hospital for two weeks without much relief of the joint symptoms. We gave chaulmoogra oil orally and intramuscularly and really a remarkable transformation resulted. He became practically another man. He helped around the wards and had notably a better disposition. I have not heard from him since his discharge. Another case of interest was a man that came in about the same time. While he showed definite improvement in the hospital, on being discharged about three weeks ago, he has now returned because he has the same

symptoms with which he came in initially. He did not have at home the benefit of chaulmoogra injections. After being in the ward for a week and having two injections, he is feeling much better. Both men reminded me when it was time for their injections—in spite of the discomfort that follows them.

Dr. McIlhenny (closing): I have very little to add to what I mentioned in my paper.

In reply to Dr. Moseley's question about crude oil, this is, so far as we know, the crude oil as put out by Parke, Davis and other drug firms or wholesale manufacturers. It is the crude oil that is being used at the National Leprosarium. It is not hydrocarpate or the chaulmoograte, or any of the ethyl esters, it is pure, crude oil, mixed with olive oil and benzocaine, filtered and sterilized.

It might be of interest to state that in discussing the question of the value of chaulmoograte or the hydrocarpate or ethyl esters with Major Denny, Commandant at Carville, in connection with my experiment in arthritis with crude oil, he said that he was not at all convinced that there was any value in the ethyl esters as compared to crude oil. He feared when reducing to the ethyl esters they lost a great deal that was possibly beneficial in the crude oil, so he preferred the crude oil in the treatment of leprosy to the other preparations.

I am rather inclined to his idea. Since crude oil, if given in proper doses, does not cause any great amount of pain, since, if an abscess forms, it is a sterile abscess which, when evacuated, gives no further trouble, since it has not any deleterious action on any organ of the body, since patients bear it very well, since they do respond to the treatment and, if nothing more, are relieved of their pain, I am rather inclined to take his advice and use a crude oil.

I have had no experience with the refined product.

In reply to Dr. Loeber-Ballard's question about referring cases she has mentioned to our service, from the description of the first case, I judge, possibly, we might hold out some hope to that individual. Although we may not expect to get restoration of function in joints already affected, we could expect reduction in symptoms and relief of pain.

With reference to the second case, where arthritis is already established bnt not so far advanced, I think we could restore considerable function.

In the third case, where arthritis has just begun, we might be able to arrest it absolutely.

I am possibly leaning too much to the optimistic side but I have not yet seen a case that has not improved, and have not had a case returned to the hospital for a second course of treatment.

Through the courtesy of the Parke, Davis people we will soon be able to get this drug put up in enteric capsules, and they have advised me a supply will shortly be coming so I can give it here at the hospital. The preparation has to be put up rather carefully and it requires some forty-eight hours to put it through the necessary processes. If the demand for it warrants, I believe we can arrange to have it put up in sterile containers so it can be available almost anywhere.

UNDULANT FEVER—A PUBLIC HEALTH PROBLEM.*

P. A. KIBBE, M. D.

NEW ORLEANS

A complete description of undulant fever in all its phases is not at this writing possible. However, as it belongs in the domain of public health, the knowledge we have is important to those who are even remotely concerned with the education of the people in the means of health protection.

In the medical history of fevers, we find reference to the "protracted" fevers of the time of Hippocrates. Whether it was this type we have no definite evidence. But in the eighteenth and early nineteenth centuries many records tell of the fever occurring on the Island of Malta. In 1859 Marston gave a full and accurate account of "Mediterranean remittent" or "gastric remittent fever." Thus between 1860 and 1870 undulant fever became a distinct clinical entity. In 1887, Surgeon Bruce demonstrated the etiological agent of the infection. He cultivated the causal organism and reproduced the disease in experimental animals. It was about this time—1904-1917—a commission was appointed on which were representatives of the Army, the Navy and the Civil Government of Malta. The detailed and laborious studies of the Commission determined the nature of the infective organism. They demonstrated that the "micrococcus leaves the body mainly through the

*Read before the Louisiana State Medical Society, New Orleans, April 14-16, 1931.

urine; that goat milk agglutinates the organism." Also that the "germ was isolated from such goats although the organism did not seem to affect injuriously such animals, even when they lived in the blood stream and were secreted in the milk." The source of the discovery was almost an accident. Small laboratory animals being unavailable, six goats were purchased for experimental purposes. That the animals were naturally infected was soon proved. It was then a simple matter to show that goats were the common source of infection.

In this country in 1904, Craig established the diagnosis of a case in a nurse who had never been out of the United States. He then suggested that many cases supposedly atypical typhoid were really undulant fever. In Arizona, a goat raising area, in 1922, there was an epidemic which gave opportunity for study and experiments.

As far back as 1896 Bang discovered the casual organism Bacillus abortus. He did not suspect the relation between the organism he had discovered and that of Bruce. A comparison followed and the etiological agent of contagious abortion in cows was determined. Miss Evans made an important contribution when she proved that morphologically, culturally, bio-chemically and by simple agglutination test, the Micrococcus melitensis and Bacillus abortus were indistinguishable.

It was then accepted that Malta or undulant fever may be caused by the Brucella melitensis of goats, the Brucella Bang of cattle and the Brucella Traum of pigs.

There are three varieties of the melitensis and two distinct types of the variety—abortus—bovine and porcine.

The disease appears in sub tropical and temperate climates. It is known to exist in Russia, Italy, France, East and South Africa, North and South America and in the West Indies. Infectious abortion of cattle also occurs widely in all stock raising countries.

In the calendar year of 1929, 975 cases were officially reported to the U. S. P. H. Service with forty-one deaths. The 1929 distribution was seasonal the number of cases increasing to September after which there was a sharp drop.

The disease had been made reportable in many states. In Louisiana it was added to the reportable list in March, 1929. Seventeen (17) cases were reported that year and twenty (20) in 1930 with two (2) deaths each in 1929, 1930, directly charged to this disease.

The large number of cases in the U. S. focused attention upon the apparent cause and investigations to show the possible virulence of the different varieties were given a new impetus. One of the most thorough and detailed of these was conducted in Porto Rico. The records and results were published in the Porto Rico Journal of Public Health and Tropical Medicine in the September issue of 1930.

The range of experiments is of interest. Blood serum was examined for abortus from 10 per cent of the entire number of animals. The seventy-nine dairies supplying milk to San Juan were visited. Of 528 samples, 312 were positive, a total of 58 per cent positives. All herds examined except six, had reactors among the samples taken. It may be well to add here, data gathered in Illinois, where tests were given of more than 5000 cattle distributed over 35 counties, show that one of every five animals is a reactor to the aggluntination tests.

Vaccination against bovine contagious abortion was tried. Living and dead cultures were used. The conclusion was "vaccination with living cultures is superior to the dead culture injection and that it reduces the number of abortions occurring in infected herds." Further study is recommended under competent research specialists.

Transmission experiments were tried on human subjects and animals. From these

"it seemed infection took place more readily through abraded skin than through the gastro-intestinal tract." Infection through unabraded skin was not accomplished but further attempts with larger doses should be tried.

Of fifty cases inoculated by various methods only ten contracted the infection—six through abraded skin, four through the gastro-intestinal canal. Of the six infected through the skin, three were inoculated with bovine, one with melitensis and two with porcine strains. The significant fact is a single dose was enough to produce in these cases infection. Of the four inoculated through the intestinal tract porcine strains were used with two, melitensis with one and one with a bovine strain. Two or more doses of the porcine were required and seven consecutive doses of the bovine to produce a mild case with the bovine strain. A single dose only produced infection with the melitensis strain. "We are therefore under the impression that only the most virulent bovine strains, when ingested in sufficient doses are of danger to man." Smaller doses through abraded skin will cause infection.

This result accounts for the number of cases that occur among farmers, laboratory workers, veterinarians and packing house employees. Persons engaged in these occupations make up about 40 per cent of the cases in the United States.

Undulant fever, in severity and duration of symptoms, may be divided into four types:

1. Fatal.
2. Severe or moderately severe.
3. Mild.
4. Ambulatory—the types are also given as the malignant, the undulatory and the intermittent.

The symptoms—generally—of each type is as follows:

Intermittent: Onset insidious, afternoon weariness; general aching; some headache, a distaste for food, chilliness in the early evening and moderate insomnia and sometimes a suspicion of fever. Backache, stiffness or pain in the neck and joints, constipation and loss of weight—later, night sweats and repeated rigors. With mild infection, the patient may be up in the morning but glad to rest in the afternoon.

Ambulatory: All symptoms of the intermittent type, though mild in degree—the usual symptoms frequently the only one being weakness or lack of endurance—temperature normal in the forenoon, rarely 101° in the evening.

Undulatory: Distinguishing characteristic, occurrence of relapses—equal in severity the milder and moderately severe intermittent form.

Malignant: Sudden onset, high temperature with an extreme hyperpyrexia before death, great prostration, severe headache and backache, marked anorexia, and usually true rigors and constipation, delirium and coma.

Intermittent type duration—six weeks to four months—sometimes prolonged—infection terminates fatally.

Ambulatory—duration—varies from two weeks to several months, often more than one month and less than four.

Undulatory—duration—uncertain.

Malignant—duration—about three weeks.

Undulant fever may present the clinical manifestations of typhoid fever, tuberculosis, bronchopneumonia, meningitis, cystitis, rheumatism and various surgical conditions.

Although there is a general optimism concerning bovine infection, it is gratifying that the eradication of this specific organism is a probability in the near future. Since January 1, 1931, in Louisiana, more than 65,972 cattle have been tested for

tuberculosis. The abortus test has also been given in some instances. Few cattle have reacted to either. By the middle of July, 1932, the work will be completed and our people will be largely protected from these milk-borne disease.

There are wide differences of opinion as to the causative agent of the disease in our own country. In 1929 King and Caldwell expressed the opinion "that raw milk infected with Brucella abortus produces agglutin and causes undulant fever in man."

In a splendid symposium on this subject at the 1929 meeting of the American Public Health Association it was stated "our study of the disease shows clearly that B. abortus is only slightly pathogenic for man and it must be that only most virulent strains in milk are of danger to him." (Carpenter and King.)

It is thought by some—notably Orr and Huddleston—who have studied the epidemiological aspect in Michigan, that "among the human population susceptibility to infection B. abortus, bovine type is very low and that human infection is determined by some factors yet undetermined." It is this element which makes a complete resume of the subject impossible. But we realize the extent of the infection; we know something of the factors; we know the symptoms; we are warned diagnosis is not easy—for these reasons it is wise and pertinent to keep undulant fever in mind.

Study of improved methods of diagnosis and treatment; investigations of the several yet undetermined factors which appear for example in many places where there is a high percentage of cattle infection there is a low human incidence of the disease and complete clinical and epidemiological records are specia'ly pertinent and will be helpful in pointing the way toward control and final eradication of undulant fever—now unquestionably a public health problem.

DISCUSSION.

Dr. J. M. Bodenheimer (Shreveport): Dr. Sandige has asked me to be a pinch-hitter this morning for the simple reason that I have had a little experience in the treatment of undulant fever. There have been four cases reported in Caddo Parish. Three have been in my private practice, the fourth I have seen in consultation. Of the different types of cases, we have seen the acute fulminating type and we have seen the ambulatory type, and the other cases have ranged between the two.

One of my reasons for coming down here to this meeting was to find out how to cure undulant fever. I expected Dr. Kibbe to tell us something along this line, and I hope some of those who will discuss this disease, following me, will tell us how to cure the disease. I used mercurochrome intravenously in 1 per cent solution, and the patients reacted very favorably to this treatment in three of the cases.

The fourth case, which I now have under treatment, has been sick for something like ten weeks, and she is still running a temperature and is still in bed, for the simple reason that I don't know what else to do with her. We tried the mercurochrome treatment without any effect. I read in Clendening's latest edition that his friend Fred Angle had a vaccine with which he had cured twenty cases, and so I sent up to Kansas City and got some of this vaccine and I gave this lady a dose of it. After two weeks' time she still swears it was meant for a cow and not for her. The reaction is tremendous. Dr. Angel says he gives four doses, four days in succession, but all I can say is that the fortitude of the people around Kansas City is much greater than the fortitude of those around Shreveport because the prostration was so severe it was impossible to induce the patient to take the second dose.

One of the things that impresses me very much about undulant fever of the ordinary type, is that the patient just has fever and is not sick. There are practically no diagnostic physical signs. This case that I still have under treatment and that I have watched very closely and have done a lot of laboratory work on, is apparently in as good health at the end of ten weeks as she was in the beginning of the treatment. About a week ago we made a routine blood examination and we found that her blood cells were 4,500,000, and hemoglobin was 80 per cent.

One of the curious things about this disease is that after all that length of time she doesn't seem to have anemia. I notice most writers on the subject say there is a mild form of anemia in these cases.

The symptoms of the disease that impress me are the profuse night sweats, insomnia, and loss of appetite. I say there are no physical signs—nothing that you can put your hands on. The symptoms are almost entirely subjective. This last case is a very intelligent woman and she watches her condition closely and keeps notes on it, and I have been able to learn a good deal from her case alone. I promised her when I came down here I was to bring something back to free her of the fever.

I notice that most of the textbooks and most of the writters (I say writers because there is very little in the textbooks) say that the disease will wear itself out. I doubt this very seriously. One of the first cases I treated had been under observation for seven years, and had been to bed at least three times under treatment for tuberculosis. That is one point I want to make. I think there are a lot of cases of these so-called cured cases of tuberculosis—these border line cases that go to bed for three months and then get up—that are really, if the investigation is carried out more fully, undulant fever cases. If you observe these cases carefully—at least it observed in these three or four cases that I have treated—from time to time you can hear a few rales scattered about throughout the lung, and with a little rise of temperature, if you are not thinking of undulant fever, you will certainly be suspicious of tuberculosis. Even if you have an roentgen-ray taken, it is a very poor roentgenologist who can't help a friend out and find a little spot if that friend has a case he hasn't been able to diagnose.

To sum up, I think there are a lot of cases of undulant fever scattered throughout Louisiana and other parts of the South, and other places for that matter, that have remained undiagnosed, and I think if we begin to study this disease more fully and know more about it we are going to report a great many more cases than we are reporting today. I know that right in my practice now I have several cases I haven't been able to prove, and I feel satisfied we will prove them eventually. We hadn't reported any of these cases as undulant fever until the State Board of Health pronounced them undulant fever. We have gone further and sent the blood to the Hygienic Laboratory at Washington for confirmation. When we get a slight agglutination in our private laboratory we are not going to call it undulant fever. As I said before, I believe there are going to be many more cases diagnosed as we learn about the disease.

Dr. M. D. Hargrove (Shreveport): I have nothing new to add to the knowledge of undulant fever but wish to report two rather interesting cases. One, a lady in Shreveport, who last summer made a trip into old Mexico, staying about three days, but during that time used goat's milk. She came home and in about two or three week's developed temperature. We thought it was malaria or typhoid and everything else before it ever dawned on us that it was undulant fever. Her blood was positive for the melitensis. She got well without any treatment at all, practically speaking; nothing that did the fever any good.

Another patient with undulant fever of the abortus type had been running temperatures for about six or eight weeks, with slight remissions during that time. We treated him in a similar way, giving him nothing in particular. Finally, we decided that perhaps it would be well to try mercurochrome, and gave him one injection 10 c.c.—½ per cent. His temperature went to normal within twelve hours and remained normal.

I am not a very ardent believer in the value of mercurochrome, but it would seem that it had some effect in that particular case.

Dr. P. A. Kibbe (New Orleans): I want to thank the doctors for their discussion.

I am awfully sorry I can't give Dr. Bodenheimer a cure for undulant fever. I think the treatment is mostly symptomatic, and the duration is from two weeks to months.

TATTOOING—A BRIEF REVIEW OF ITS HISTORY, PATHOLOGY AND METHODS OF REMOVAL.

PAUL D. ABRAMSON, M. D.,

SHREVEPORT, LA.

Tattooing is the introduction of pigmentary matter into the skin, usually intentionally and in a definite design, but sometimes the result of accidental penetration as following a gun explosion at close range. Its interest to physicians is mainly two-fold: first, because of the occasional complications which are attendant upon the application of the tattoo, and secondly, not infrequently the problem of tattoo removal is presented to the physician. In addition, tattooing very occasionally finds a legitimate use for cosmetic purposes or after plastic operations. No doubt there would be many more opportunities to remove tattoo marks if the idea were not so prevalent among the profession as well as

among the laity that these marks are permanent and practically ineffaceable, or only removable at the expense of an extensive and mutilating scar. As a matter of fact, most such marks wherever placed are amenable to removal with a minimum of scarring.

The word "tattoo" is in reality a Tahitian word "tatu," derived from "ta" meaning "mark." It was among these Polynesians that the art of tattooing reached some of its highest development. The exact origin of this peculiar onanistic custom is uncertain and lost in the dim realms of antiquity. According to Shie, however, its incipiency was probably from the ancient custom of slashing oneself as a token of grief over the loss of a tribal chief or a loved one. Those marks into which ashes (carbon) were accidentally introduced were found to be more permanent than the others, and gradually the custom arose of deliberately placing pigmentary matter (at first carbon) into these cuts in order to make a permanent record, as it were, of some previous grief. Death always having been closely intermingled with religious beliefs, it was but a natural step for these markings to assume a religious significance. Gradually, instead of aimless slices about the body, the marks were made with some definite design or emblem, and thus we have the first definite tattoo as it is known today.

Although tattooing in its beginning probably had more of a religious significance than anything else, it is interesting to note that it was prohibited under ancient Mosaic Law (Leviticus XIX, 28). Soon the various peoples who were practicing tattooing found other uses for it. Painting the face and body as an aid in warfare, to frighten the adversary, dates back to remote antiquity. With the advent of tattooing, tattoo marks replaced part of this warlike array. Gradually certain marks became distinctive of tribes and even individuals. In New Zealand, for example, tattooing of the face or "making the moko" as it was called, reached an extremely high degree of individuality and no two faces were alike; and these mokos served as a mark of distinguishment. On the purchase of land in New Zealand from the natives in 1815, the mokos of the chiefs were copied by them as their signatures to the deed.

As civilization has advanced, the practice of tattooing has fallen from one of dignity and significance, to one practiced by charlatans and street fakirs upon gullible and frequently irresponsible (at the time) individuals. Nowhere has it reached the peak of development which it did in the Islands of the southern Pacific (Polynesia) and Japan. In ancient days this practice was an honorable calling handed down from father to son, but now the "tattooer has lost his caste, and tattooing its art."

In modern times tattooing is usually seen in sea-faring people or in individuals who are tattooed under the influence of alcohol or in a spirit of bravado. Not only has the purpose and significance of these marks changed, but likewise have the methods. At first it was accomplished by the rubbing of pigment into open cuts; then there came the use of bodkins or chisels composed of bone or steel, and mallets: specimens of these have been found in the most ancient Egyptian tombs, these instruments usually being shaped like a little hoe. From these methods there gradually evolved the use of the needle, at first hand-operated, but later, in modern countries, electrically run.

Tattooing has been quite a widespread custom, having been found in practically every civilized and in most uncivilized countries, and presumably its origin has been similar in each instance. However, in certain places it is absent, either as the result of unfavorable legislation, or because of some superstition. Thus in Russia, according to Witthaus and Becker, until comparatively recent times, tattooing was found only in the prison camps

of Siberia because it was regarded as a mark of alliance with evil spirits. In Cleveland, the practice is prohibited by law; in Norfolk and in San Francisco it is subject to strict regulation. In other places, while the practice of tattooing is not subject to legislation, the removal of tattoo marks is construed as belonging to the realm of medical practice. In Japan, the practice has been prohibited for a number of years, and likewise the French government is said to prohibit it amongst its enlisted men. Tattooing has at times been used as a mark of identification, or for the branding of a criminal, this having been practiced in ancient Rome. At one time, a bill was almost passed by the French legislature to mark all new-born infants as a method of permanent identification.

The pigmentary substances (carbon, india ink, indigo, mercuric sulfide, red lead, etc.,) used in tattooing are introduced not only into the stratified layers of the epidermis, but into the superficial layers of the corium as well. Apparently the pigment is carried into the layers deeper in the corium by the action of phagocytes, and the pigment can at times be recovered from adjacent lymph nodes. Most of the colors, unless treated, are permanent. It is said, however, that professional tattooed people are re-tattooed every ten years in order to keep the colors bright. That they are quite permanent is evidenced by the fact that tattoo marks have been found on Egyptian mummies dating from 4000 B. C.

Tattooing has other uses than for purely ornamental purposes. In surgery it has been used to obscure certain facial blemishes or to color lips after cheiloplastic operations. It is said that on the West coast permanent rouge or lip stick is tattooed into the cheeks or lips as the case may be.

Complications arising from the application of tattoo marks are not nearly as frequently seen since the introduction of modern methods of tattooing as they were formerly. The abandonment of the practice of rubbing saliva, urine, and what not, into the marks to make them "take"; and the preparation of the field before tattooing has been a large factor in the reduction of the morbidity. Some idea of just how much trouble used to result from this practice is indicated by the report of Bercheron's published in 1862. He reported 43 cases in which 8 deaths occurred as a direct result of tattooing; in 8 others, an amputation was necessary; in 25 others there was marked inflammation and infection. The types of infection resulting from tattooing have varied from a simple localized inflammation to septicemia and death and have included such infections as leprosy, tuberculosis and tetanus. In some localities, so many cases of syphilis have been transmitted by a tattooer that a tattoo mark has been considered as tantamount with a leuetic infection.

There have been innumerable methods advocated for the removal of tattoo marks, indicating, obviously, that no method is entirely satisfactory. Thus Cattani has enumerated thirteen distinct procedures designed for the effacement of these pigmentary deposits including simple blistering, the use of carbon dioxide snow, use of mother's milk, Finsen rays, digestion with papain, cold cautery, etc. However, of all these methods advocated there are only three types of de-tattooing that are of any great value, viz.: (1) surgical, (2) electrolytic and (3) chemical. Each method has its exponents and probably there is some value in each of these methods.

The surgical procedures consist largely of either excision of the entire tattoo mark, suturing the skin edges together, or skin grafting the area; or of removing the superficial layers as in making a Thiersch graft, thus exposing the pigment so that it can be picked out; or by dissecting up a flap containing the pigment, picking out the particles and sewing the flap back in place (harpooning method of Wederhakein). The

two latter are too time consuming to be of much practical value and the former has definite limitations depending upon extent and location of the tattoo.

Keller and Miller have been proponents of the electrolytic method: a 2-3 milliampere galvanic current is used, the needle being connected with the negative pole, the softening action of the alkali on the tissues permitting removal of the pigment. Cattani found the method unsatisfactory, requiring numerous applications and uncertain in its results.

Numerous chemical methods have been advocated but of these there is one that is predominantly useful and, according to recent writers, is the best method of all for the routine removal of tattoo marks. This is the French tannic acid-silver nitrate method first advocated by Variot and modified by Shie. Since Shie's report in 1928, Korb (1929) has reported its use in 28 cases: he removed the design completely in 8 cases; in 12 only a small amount of deeply placed pigment remained, and in 8 there was incomplete removal. In all there was only a minimal amount of scarring and he was well pleased with the method.

Briefly, this method is as follows: the area to be de-tattooed is prepared as for a surgical operation. Then using 50 per cent tannic acid, the entire area is re-tattooed using either a regular tattoo needle, or a short piece of ⅜ inch brass tubing into the slightly flattened end of which are soldered 10 fine needles; or simplest of all a cork may be used into one end of which is embedded 10-15 fine needles. This re-tattooing is done through a layer of tannic acid which is kept on the mark while the tattooing is in process, replenishing as necessary. When the operation is completed the entire area is closely covered with needle marks and the pigment is almost obliterated by a grayish tint and by numerous fine droplets of blood. The excess tannic acid is then removed from the surrounding area by washing in cold water. Sterile vaseline is then placed on the skin around the tattoo marks as a protection to the normal skin during the next step. A stick of silver nitrate is then rubbed vigorously into the area thus marked out causing a heavy deposit of silver tannate in the corium. The vaseline is then removed and the area washed with cold water. A dressing of tannic acid or a simple sterile dressing is then applied. No anesthesia is required for this procedure as the patients do not object after a little tannic acid is tattooed in. The tattooing is carried to ½ inch beyond the area of the original tattoo mark. In about 12 hours the area becomes hard and leathery and all protective dressings may be abandoned. In 14-16 days this black covering comes off, leaving a pinkish area which gradually becomes white, and resulting in scarring that is scarcely noticeable. This method is applicable for the removal of accidental (e. g. gunshot) as well as intentional tattooing. If necessary, the process may be repeated to remove any areas not completely de-tattooed.

SUMMARY AND CONCLUSIONS.

(1) Tattooing is an ancient custom which through the ages has changed both in significance and in methods of application.

(2) The pigmentary particles are, in part, introduced into the true skin, or corium; hence the usual indestructability of the tattoo marks.

(3) Numerous methods of tattoo-removal have been recommended, of which there are three principal types, viz.: (a) surgical, (b) electrolytic and (c) chemical.

(4) Of all these various methods, the tannic acid-silver nitrate method, originated by Variot and modified by Shie, is probably the simplest and most effective method for general use.

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ADDRESS OF WELCOME ON BEHALF OF THE LOCAL PROFESSION.*

EMMETT IRWIN, M. D.,†

NEW ORLEANS.

Mr. President:

Today, you the members of a great Medical Society, the representatives of a beloved and honored profession are the guests of the Orleans Parish Medical Society. It is an extreme pleasure and happy privilege for the members of the medical profession of New Orleans to be your host.

It is only fitting that you should assemble each second year in New Orleans for this City is one of the prized possessions of the people of Louisiana. It belongs to you as to us, in the same manner as the profession of New Orleans is a part of you and you a part of it,—all working in harmony and unison for the promotion of the health of the people.

The physician occupies a highly important position amongst his fellow citizens and they look to him with regard and respect. His place is quite unique in this life of strife and turmoil. It is to him his patient unfurls the sacred secrets of the innermost recesses of the heart with a feeling somewhat of relief, and at the same time with a profound confidence their secrets shall not be revealed. Think, then, Gentlemen, of this lofty and exalted level to which our profession carries us and I wonder how often does one ask himself, "Do my actions as a man and in my profession justify such degree of respect and confidence?" However, if a man is honest with himself to the degree of a sincere and satisfied conscience, then he need not fear for his fellow men will have been likewise satisfied in the deeds which he has performed—when he has done his best, he has done well.

One of the great problems in Medicine today is the prevention of disease and the public must be made conscious of the extreme necessity of keeping their bodies in good physical condition through frequent periodic physical examinations. In this way early and incipient disease is detected when in a curable state rather than in the final and hopeless stage. For the past several years the Orleans Parish Medical Society has sponsored a Longer Life Week during which an educational program has been carried out with the idea of impressing upon the people of the community the necessity of a periodic health examination. Every well conducted business takes stock at least annualy to determine the state of its affairs. Is not the business of life about the most important business with which any man is concerned? Then why not make a yearly audit of the body mechanism to determine the degree of wear and tear upon its various parts and organs? It is in this way we may expect to aid in prolonging life, a most desirable hope of ecah one of us. This plan is recommended to the various parish organizations.

It is not appalling to think approximately one person in every ten is subject to cancer? And of this number 20 per cent have cancer of the stomach. On a recent visit to one of the large Clinics of this country a prominent member of the Staff

*Read before the Louisiana State Medical Society, New Orleans, April 14, 1931.

†President, Orleans Parish Medical Society.

reported that of the patients coming there who suffered with cancer of the stomach 50 per cent were grossly evidently inoperable and were sent home. Of the remaining 50 per cent half again showed upon exploration the disease had already progressed to a degree where there was no possible aid from surgery. Therefore only 25 per cent of all cases of cancer of the stomach seen at that Clinic come in in an operable state. Why is this? They either do not consult their physician early enough, or the physician does not recognize the condition, or the patient has not followed the advice of his physician.

Unfortunately, there are more corner druggists prescribing medication for peoples' ailments than are doctors. This is a pernicious habit and extremely detrimental to the well-being of the community. While the people should be educated not to become corner drug store patients but should have a complete study of their stomach complaints by a competent physician, at the same time the physician himself should not become a drug house doctor having the slogan, "After eating reach for baking soda." The best remedy for these astounding figures on cancer, is through early medical advice and thorough examination, always erring on the side of safety to the patient.

Medicine has always had an economic position in the business of the community and it shall continue to occupy a close relation to business. Certainly New Orleans itself owes its existence and progress to the discoveries and accomplishments of Medicine. It has not been beyond the memory of many of you that this section was cursed with the most feared and dreaded diseases. Chief among which were yellow fever, bubonic plague, smallpox, typhoid fever and malaria. These were bad enough in themselves, but the psychological effect exerted a demoralizing influence upon our population and prevented tourists from visiting our City, diverted settlers and business into other regions, thus retarding the economic and industrial growth of the Community. The former, yellow fever and bubonic plague, have been eradicated, while the latter three, smallpox, typhoid and malaria, are curiosities by comparison.

You can recall the unsanitary condition of the open gutters, filled with garbage and slime, alive with larvae, the cisterns a breeding place for the mosquito, the surface out-house toilets, all constituting means for the transmission of disease.

With the elimination of these through improved sanitary measures our community was transformed from an undesirable and dreaded place in which to live into a City of health and beauty and prosperity. No longer does one fear to visit here, no longer do the inhabitants themselves flee to other climes to escape ill health.

So today when one gazes in wonderment upon the mighty Mississippi as it rolls its way to the Gulf, viewing great merchantmen engaged in commerce with the four quarters of the globe, as one looks at the towering office buildings, virtual beehives of humanity, as one sees a busy populace bustling along magnificent streets and boulevards, as one visits the wonderful public schools, he realizes the great expenditure of wealth, the triumph of architecture and engineering necessary for such, but he fails to reflect and become conscious of what really made it all possible—the elimination of disease and improvement of sanitary conditions through accomplishments of medical science.

Even now a new order of things is being created in the professional history of our city. Just as New Orleans is facing a great advance in her business, so also is the medical profession facing a great advance. She has always occupied a strategic position of medical education and her fame is known throughout the world. We are blessed with a capable and competent profession. We are fortunate to have this grand temple of learning which houses our great Tulane Medical School possessing an enviable and

glorious reputation for medical teaching. We have the magnificent clinics of our great Charity Hospital with its vast volume of material a great portion of which has never been cultivated. There is the Medical School of our splendid State University, and now comes the Mid-winter Clinics. So, with all these organizations co-operating harmoniously, in a great spirit of sympathetic understanding for the common purpose for which all medical schools and associations are created—the efficient training of physicians to enable them to efficiently care for the sick—it is believed New Orleans shall become with these advantages the mecca for medical training in the United States.

Then, gentlemen, you must yourselves realize you are a part of the profession of New Orleans and you must join with us in the proper enjoyment of these privileges. The members of the profession of our city express greetings to the visiting members of the Louisiana State Medical Society, extends the happy hand of fellowship to you, and hopes your stay will be as pleasant for you as we assure you it is for us. Welcome.

RESPONSE TO ADDRESS OF WELCOME*

S. C. BARROW, M. D.,†

SHREVEPORT, LA.

Mr. President of the Orleans Parish Medical Society, Mr. Mayor of the great city of New Orleans and Your Excellency, the great Governor of the great State of Louisiana: On behalf of the Louisiana State Medical Society, I wish to thank you for your kind words of reception and your hospitable welcome, and assure you that individually and collectively they are appreciated.

In coming to the city of New Orleans, however, in annual convention we come not as strangers among strangers, but we come as friends to mingle with friends in furthering a cause than which no nobler exists, the advancement of the aims and ideals of organized medicine.

In the days gone by, there seemed to exist an intangible barrier between the people and the doctors of New Orleans and those of the state at large, a barrier which seemed to rear its head in dissension in all matters of debate, political, civic or scientific. However, through the processes of evolution the differences have been smoothed out, misunderstandings to a great extent have been forgotten, and we are today one people, one scientific, civic and political democracy.

Louisiana has always recruited leaders, and able leaders, from among her ranks. In the dark days of the past, according to history, there arose leadership to meet every crisis in every department of life. For the future and present we have no fear.

Dotted throughout our state today in every community we find hospitals thoroughly equipped and properly manned to care for the needs of the sick, and thanks to the civic genius of our distinguished fellow citizen, leader and Governor of the state, there are now, and being constructed great permanent highways making accessible these and other facilities to all.

Organized medicine claims a big part in the development of Louisiana, we realize thoroughly there is yet much to be done, many plans to be made, and it is for this purpose that we are now assembled in your city.

My function, Mr. Chairman, is to respond to the address of welcome. As President-Elect of the State Medical Society I crave one moment to say that it will be the aim of the state administration, the state medical administration, for the next year to maintain harmony and scientific progress to its utmost ability. I am sorry after there seems to be a thorough amal-

*Read before the Louisiana State Medical Society, New Orleans, April 14, 1931.

†President-elect, Louisiana State Medical Society.

gamation of the interests of the country with the city in medical matters we should find a little spirit of antagonism among the profession of this great city, a spirit which should not, must not, and has no reason for existing, a feeling which I am confident will be smothered out and harmony will reign. Should there be any necessity for effort to be exerted by the medical administration of the state, it will be forthcoming if desired, in the interest of all.

I thank you, Mr. President, on behalf of the State Medical Society for your cordial words of reception, for we know, as we have learned in the past, that they are spoken with true sincerity.

CASE REPORTS AND CLINICAL SUGGESTIONS

A CASE OF NEUROLOGIC INTEREST.*

CECIL LORIO, M. D.,

BATON ROUGE, LA.

R. M. D., of Baton Rouge, Louisiana, white male, aged 11 years, weight 75 lbs, healthy other than the present condition. *Past history:* Father and mother living and well No history of epilepsy, severe headaches, insanity, asthma, rheumatism, cancer, or tuberculosis. Five pregnancies, one of which was a miscarriage, 2 months, between the second and third child. Four living boys, one married with two health children. *Birth history:* Child was born January 1, 1920, high forceps delivery, weight 8½ lbs., labor very hard and much prolonged. Following birth, the baby was easily resuscitated, no cyanosis, cried and nursed vigorously. His general condition appeared good with the exception of an abrasion over the right occipital region due to the pressure of the forceps. The attending nurse was of the opinion that there was some injury because of a great amount of crying, though the records did not show any temperature or signs of irregular respirations nor was there any history of protrusions of the tongue or holding the head backwards. *Past history:* The usual diseases of childhood, including measles, chicken-pox, whooping cough between 3 to 5 years of age. First teeth at 7 months, sat erect at 6 months, walked at 10 months, talked at about 2 years with no apparent disturbance of speech. Has not had rheumatism, growing pains, chest diseases, or brain diseases. Removal of tonsils and adenoids was done at the age of 2. *Complaint:* Epileptic spells, lack of proper function of the right arm and leg. *Present illness:* The present condition made its first appearance when at the age of 4½ years the father was playing with the child, holding him by both arms swinging and tossing him over his back he noticed that the child complained of a pain in his right arm. The father thinking that he had dislocated the arm made repeated attempts with tension to reduce a supposed dislocation but the next day the arm was apparently normal and not painful. Three months later the mother noticed a tremor of the right hand, lasting about 1½ minutes, and her description of it was that of a tonic contraction of the muscles of the hand; this condition occurred three or four times during that year. About the age of 5 years the family noticed these tonic convulsions were involving the entire right arm and at once consulted an orthepedic surgeon in Oklahoma City where they were residing. The child was complaining that his arm would go dead at times which was brought on mostly following intense exercise. During the visit to the orthopedic surgeon and while in the office being examined by the doctor he developed one of these attacks in the right arm which lasted about 1 minute and which the child described as though electricity was running through it. Immediately he referred the child to a neurologist who diagnosed it as Jacksonian epilepsy and treated it with small doses of luminol, which was ineffective. From then on the child's condition grew progressively worse. The convulsions of the right arm and shoulder were not accompanied with any loss of consciousness or dulling of the sensorium, nor was there any parasthesia or disturbances of sensory function. At this time the attacks were at intervals of one to three weeks. Somewhile later there seemed to be a spreading of the areas, gradually involving

*Presented at the Louisiana State Pediatric Society, April 13, 1931.

the entire right half of the body. About the age of 5 some of the attacks were accompanied with a lethorgic state. During November, 1925, at the age of 5 years, the child was taken to a brain surgeon in St. Louis, who made a tentative diagnosis of left cortical tumor, suggested operation, but was postponed and gave luminal treatment. From this time until the fall of 1926, one year, the child went to school, was entirely free from attacks and led his classes in a most precocious manner, but the attacks then returned and were involving the right face, arm and legs, and occurring three to four times a month, and each spell was accompanied with euphobia, continuous chattering, but no loss of consciousness. January, 1927, he was taken to the Mayo Clinic, where complete examinations were made with a diagnosis of Jacksonian epilepsy; advised against operation and put on a ketogenetic diet which was maintained under the strictest supervision. Two months following, the arm and hand began showing deformity, the forearm being flexed on the arm and the hand flexed on the forearm, so that the position was flexion, making it practically useless in the performance of his regular duties. The tonic convulsions at this time were as many as 10 to 14 a night, none during the day, occasionally being accompanied with unconsciousness, but at no time was the leg or arm paralized. In February, 1928, at which time the attacks were very frequent and severe, he was returned to the brain surgeon in St. Louis. Roentgenograms showed convolutional markings but no tumor shadow. A craniotomy performed, finding a typical looking epiplytic cortex with engorgement, ironing of part of the gyri, increased ventricular pressure, but no tumor. The arm motor center was located in the prerolandic area by means of the galvanic current and it was found that it lay directly under a very large Krause vein which he did not care to excise as it might have caused marked symptoms. He, therefore, injected alcohol into the cortex with the idea of destroying the arm center (a procedure which since then has been given up). With a thorough needling of the cortex he could not locate a tumor. Following the operation the child was apparently very much improved in so much as the number and intensity of the attacks were less and a greater part of the function of the right half of the body returned: school duties were maintained at a high standard with apparently no mental defect or dulling. This improvement was fairly constant until about 18 months later in September, 1929, when the condition again became progressively worse, being accompanied each time with unconsciousness. His condition becoming grave, so much so that his left hand was being involved and he had difficulty in walking due to awkwardness and stumbling. This was the time when I first examined the child, and recognizing his severe neurological condition referred him to a neurologist in New Orleans, who examined him thoroughly and returned him with the following report:

Cranial Nerves—

I. Normal.

II. Choked disc, R. & L. about 3D, vision reduced but not measured, no field defect for form on rough examination.

III, IV, & V. No ptosis, extra ocular movements normal, no nystagmus, pupils equal and regular, react to light and in convergence.

VI. Normal, motor and sensory (corneal reflex present).

VII. Normal.

VIII. Hears watch tick normally, vestibular function not tested.

IX, X, & XI. Normal.

There is a definite paresis of the right side but no muscle is actually paralyzed; he walks with a limp and does not use the right hand although the strength is fair. The left side is also weak but markedly less so than the right—the movements of the left lower extremity are fair but those of the upper are very much impaired. The impairment which he shows is apparently due to a lack of synergic control, not a cerebellar incoordination but to the occurrence of athetoid movements; he cannot write or button his clothes with the right hand at all and very poorly with the left.

The sensorium was normal throughout, he stands in Romberg's position, there is no astereognosis.

The tests for coordination were rather poorly performed, but one was impressed with the interference by athetosis rather than any true incoordination. There was a slight tremor of the extended hands.

Superficial reflexes were present and equal, all tendon reflexes were very sluggist with little difference between the two slides, even so he would occasionally show a few strokes of clonus on the right but never sustained. Pathoiogical reflexes were not elicited. He showed no Kernig or Lasegue sign, the neck was not stiff.

One cannot escape the impression that this child is afflicted with a tumor of the brain, based both on his history and physical finding. I am aware that he has been explored by a very outstanding neurological surgeon who could not demonstrate the presence of a tumor, but my impression is that at the time of the exploration the tumor was probably present and was situated so deeply that it was impossible to reach it. It is probably near the base and near the midline, starting perhaps on the left side and now involving both sides. The signs he shows point to involvement of the basal nuclei. He has had the benefit of an exploration with a decompression and I feel skeptical as to the benefit to be derived from further surgery, but at the same time I feel now as I did then, that you should communicate with the St. Louis doctor and obtain his opinion. In as much as his seizures are becoming more frequent and are markedly increased when the luminal is omitted I believe that it is advisable to continue with this medication.

Very truly yours,

A. B.

Two months later the child's condition grew so much worse that I again sent him to the neurologist in New Orleans who then reaffirmed the diagnosis first made of a deep seated brain tumor, hopeless. Returning from New Orleans I made a complete examination and found that the child was unable to walk because of the left sided involvement. The onset of this left side development began with an awkwardness, frequent stumbling, dropping objects from his hand, spilling foods and generally nervous. With the hands extended a fine tremor was noticed with irregular twitchings of the fingers also a tremor of the tongue was noticed. Speech became much affected so that it was impossible for him to enunciate, therefore he could not be understood. The mental condition remained good and the mother was required to read to him almost continuously. Facial grimaces noticed, muscular movements were rapid, irregular, involuntary and of wide excursion. A twitching of the fingers and incoordinate convulsions of the hand and left were present. Both patellar reflexes were exaggerated with a questionable Babinski. The optic discs were normal with possible a slight engorgement of the retinal vessels. The child lay in a very restless, helpless, painless and at times listless position, unable to perform his daily duties. On several occasions there was urinary retention and only twice did he have any headaches, though there was at times a tendency towards visual disturbances. It was during the first week of this late development that the neurologist in New Orleans thought the child hopelessly affected with a deep seated tumor incroaching on the brain areas that involved the left side of the body. But, strange to say, all of the symptoms subsided shortly thereafter and the child progressively improved to such an extent that the parents were of the opinion that he was in a better condition than ever before since the origin of the trouble. About eight months later, in August, 1930, there was a recurrence of the above described condition—that is, awkwardness, stumbling, dropping of objects, spilling foods, tremor of hands and tongue, blurring of speech, rapid, irregular and involuntary muscular movements of wide excursion. This last attack lasted about three weeks to one month. Following the subsidence of these symptoms his co-ordination has not been very good and at the present time his physical examination reveals spasticity of the right arm and leg. Athetoid movements at times are rather pronounced and he is unable to control the right hand as usefully as the left. Speech decidedly blurred but has been since I have first seen him. Sensation to heat and pin point is normmal; is unable to stand erect on the right leg with the left elevated. A noticeable spasticity of the right side is present and at the present time he is having tonic convulsions of the right arm and leg and sometimes the entire body, usually about once during the night lasting two or three minutes. Grasp is unequal; he is very tired most of the time and seems to hold the head inclined to the right. When his tonsillectomy was done the uvula was removed. Wassermann, negative, urine negative, blood count normal, stool negative. Spinal punctures were not done because of the seriousness

of the child during each attack and because of the prevailing diagnosis of tumor of the brain previously made; although I do think it has on several occasions been indicated and that at any subsequent attacks I intend doing it.

DISCUSSION.

From the history, symptoms, and physical examination one is at once impressed with the regularity and progressiveness of events occurring in this child. From early childhood until the present day he has had a physical disturbance of the right side of his body indicating some type of upper neuron lesion. The attacks have repeatedly indicated pathology involving an area located between the basal neuclei and the cortex of the left side. Several of the South's most eminent neurologists have agreed on the diagnosis of tumor but have been unable to show proof. One of them attempted to locate it after doing a decompression but was unable to find it. His symptoms have been similar with every attack, having a tonic convulsion of the right arm and leg, and at times encroaching upon the opposite side as though following the anatomical location of the centers of the brain and usually not accompanied with sensory or physic disturbances, consciousness usually being present. History of trauma, infantile cerebral palsy, heredity, acute inflammatory disease of the brain, or any other referable etiology is entirely lacking. It is apparent that this child is of the Jacksonian type of epilepsy with some brain pathology, probably a circumscribed inflammation, the most common of which are due to trauma, tumor, abscess, gumma, tubercle, local meningitis, post-encephalitis and localized edema of the brain may be ruled out by symptoms. Trauma, even in the absence of history, must be considered. Vascular lesions and scar may be present without our knowledge of it. So that it would be logical to conclude that the source of the epileptic seizures is some circumscribed inflammatory area of the brain but of questionable location and type. From the history it will be noted that the child has had three severe individual and distinct attacks of a condition which does not correspond with the usual type of Jacksonian epilepsy. This refers to those periods of three to eight weeks duration when the child was sluggish, awkward, stumbling, generally nervous, dropping objects, tremor of the hands, irregular twitching of the fingers, tremor of the tongue, facial grimaces, rapid muscular movements of the irregular, involuntary and wide excursion type. The above syndrome reminds one conclusively of some type of generalized inflammation or irritability of the brain, *i. e.*, chorea. Whether or not these symptoms were the true rheumatic chorea or due to a general nerve irritation radiating from some central focus (the Jacksonian focal area) is open to conjecture. His mental characteristics appear normal and he does not have the epileptic make up—that is, of volative explosive temper, egotism, sensativeness, with impaired memory and mental retardation. Though he does not give evidence of being abnormally brilliant, his intelligence is at par. Julius Caesar, Peter the Great, Napoleon and other brilliant men had epilepsy, so that it does not necessarily indicate that this child's mental condition will be below normal. In conclusion, it may be said that this child is affected with an epilepsy of the Jacksonian type, and judging from his past treatments, both medical and surgical, it is to be expected that there will be a continuance of symptoms unless it will be possible to locate and remove the offending factors.

NEW ORLEANS
Medical and Surgical Journal
Established 1844
Published by the Louisiana State Medical Society under the jurisdiction of the following named Journal Committee:
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SUBSCRIPTION TERMS: $3.00 per year in advance, postage paid, for the United States; $3.50 per year for all foreign countries belonging to the Postal Union.

News material for publication should be received not later than the twentieth of the month preceding publication. Orders for reprints must be sent in duplicate when returning galley proof.

THE JOURNAL *does not hold itself responsible for statements made by any contributor.*

Manuscripts should be addressed to the Editor, 1430 Tulane Avenue, New Orleans, La.

THE POTENTIAL MALIGNANCY OF WARTS AND MOLES.

Under the above caption Maes* has written most sensibly in the editorial columns of Surgery, Gynecology and Obstetrics. His theme is so trite and so commonplace that it hardly seems necessary to accentuate what this sterling surgeon has written, but it is just such apparently trivial things that we are wont to overlook and certainly frequently neglect; they may not be of unusual interest but are of extreme importance. As Maes writes, these insignificant and harmless neoplasms in many instances are potentially malignant, and may untimately result in the death of the patient as a result of widespread metastases. There is no way of being able to determine the susceptibility of the individual to cancer or to the liklihood of the apparently bengin growth becoming malignant.† Therefore, it is the duty of physicians to explain to the patients the possibilities that may occur, particularly if moles or warts are subject to frequent trauma and to suggest their immediate removal, nay, to insist that they be removed promptly, either by the knife or by electro-surgery.

*Maes, Urban: The Potential Malignancy of Warts and Moles, Surg., Gynec., and Obst., 8:111, 1931.

THE PRESENT DEPRESSION

A spirit of pessimism seems to prevail widespread throughout the United States. This great country, which only a few years ago was riding high on the crest of affluence and industry, has gone to the other extreme and has dropped into the slough of economic despond. Undoubtedly a great deal of this depression represents a most interesting psychic phenomenon. Of the great bulk of Americans working at the present time, estimated at 85 per cent of the wage earning population, a goodly percentage of those that are employed have not suffered loss of income, and are as comfortable as they were in the days of great prosperity; but not so contented. There is a certain fear prevalent that things may go from bad to worse, a thought which is most depressing to these individuals who are employed. Just at the present time the financial situation seems to be improving, and it is quite possible that in a relatively few months there will be betterment in all lines of industry.

To the doctor the depression is particularly hurtful. The physicians' bills are al-

†Note case of Dr. Johnston, in Section of Hospital Staff Transactions, p. 208.

ways those that are paid last, and many people even though well able to pay the doctor are using the present situation as an excuse for postponing the meeting of their obligations to the physician. They are using the depression as a reason for non-payment of their bills and the doctor suffers. The patients who are on a fixed salary, which has not been modified by the present day conditions, are in many instances doing this, forgetting that the physician has his office rent to pay, his automobile to keep up, and his technical equipment to maintain. The only hope that can be held out for the near future is that there is some clearing of the economic sky. and the woeful fear and often spurious dread of the future will banish from the minds of those who have no reason to have it. When this happens it is quite possible that the physician will become relatively affluent for a short period at least, because, after all, unpaid bills are usually paid sometime or another, and it is perhaps possible that bills due in reasonably large numbers will come flowing in more or less simultaneously.

ARISTIDES AGRAMONTE.

Several months ago Dr. Agramonte came to New Orleans to occupy the Chair of Tropical Medicine in the New Louisiana State University Medical School. The arrival of Dr. Agramonte in New Orleans was hailed by the local and state medical profession as a great addition to medicine in this vicinity. Elaborate plans had been made by Agramonte and by the authorities of the new school for the development of an outstanding Department of Tropical Medicine. Distressing and sad indeed is it to hear that this outstanding physician apparently in the full vigor of health succumbed suddenly to a heart attack on the seventeenth day of August.

Dr. Agramonte needs no introduction to the medical profession of the United States, but to the medical world of Louisiana and New Orleans his fame and reputation is known intimately on account of the bearing that the results obtained by the United States Army Yellow Fever Commission had on local health conditions. Although yellow fever at one time had been a scourge of the entire eastern seaboard from Boston southwards, at the time the Commission functioned it was only in the cities of the southern United States that bordered the Gulf that epidemics of yellow fever were likely to occur. This Commission rendered to New Orleans, as the largest City of the South and on the Gulf, a service which can not be estimated in monetary values nor in the number of lives saved. Agramonte was one of the active protagonists of the mosquito theory advanced most forcibly by Findlay, and it was natural that he should be appointed to the Yellow Fever Commission, organized by Walter Reed. His name with that of Carroll and of Lazear will rank just under that of this great American Army Surgeon.

The life of Agramonte is one of varied interest. Born in Cuba, as a child he was taken to Mexico and when twelve years of age came to New York City. He went through the usual preliminary school and medical education to become a doctor in 1892. Apparently he was destined to practice the remainder of his life in New York City, but at the onset of the Spanish American War he promptly threw up his civil appointments and entered the United States Army. In 1902 he resigned from the Army and went to Havana as Professor of Bacteriology in the medical school of that City. In the years that intervened before coming to New Orleans, his life was a full and busy one. In addition to his active teaching and investigative work, he was the outstanding practitioner of medicine in Havana, and was almost, were such a thing possible, the official doctor to the American Colony in the capital of Cuba. During these years many honors were showered upon Agramonte, and he

was most active in various types of public health work in the Republic of Cuba.

In 1928 Dr. Agramonte was a guest speaker at the meeting of the American College of Physicians in New Orleans. He contended strongly that the concept of Noguchi, that yellow fever was due to a specific leptospiral organism, was incorrect. Time has substantiated Agramonte's contentions.

To those who knew this great Cuban-American physician his loss will be a very real one. A charming gentleman and delightful host, as those who have visited Havana well know, Agramonte was a friend worth knowing. To those who were not personally acquainted with him, the potentialities of his presence in New Orleans held out so much that his going will be equally a real blow.

HOSPITAL STAFF TRANSACTIONS

KING'S DAUGHTERS' HOSPITAL, GREENVILLE.

The staff of the King's Daughters' Hospital, Greenville, met July 8, and held a short snappy program after our dinner at 7 P. M. in the hospital dining room. The staff meets every second Wednesday in the month.

Dr. T. B. Lewis gave an interesting case report, after bringing up for discussion the subject of mortality in appendicitis. He reported some of the statistics of a prominent insurance company and others, including Dr. Evans of Chicago, showing the surprisingly increased death rate from apoendicitis in the past twenty years. The truth of this condition was challenged by our staff and especially by Dr. H. A. Gamble, who proved his point by his records of more than two thousand cases since 1918, with seven deaths or less than one-third of one per cent. The records of the other men here will probably show about the same percentage of mortality. So for this part of the State we cannot agree with the alarming reports as given.

Dr. Lewis also reported a case of appendicitis and partial obstruction of the bowel produced by a large round worm. The worm had coiled up in the ileum about twenty inches from the ileo-cecal valve and the bowel down to the cecum was completely collapsed and considerably inflamed. An acutely inflamed appendix was removed. The desire to remove the worm through an opening in the gut was overcome. The coil was broken up and left to find its way out under the influence of a vermifuge given a few days later. The worm did no further harm and the patient had a quick and uneventful recovery.

J. C. Pegues, Secretary.

CHARITY HOSPITAL, NATCHEZ.

Report of a Case of Intestinal Obstruction Due to Ascaris Lumbricoides—Dr. T. H. Rayburn, House Surgeon, in collaboration with Dr. E. E. Benoist, Natchez, and Dr. C. A. Everett, Bude.

History: C. R., colored, female, aged 2 years, was admitted to the Natchez Charity Hospital, June 8, 1931, case No. 1033.

Her present illness started three days before admission with diarrhea and vomiting of a persistent character, pain in lower abdomen, and some fever. She was given castor oil one day prior to admission which acted once. The last few hours before admission, vomiting ceased, straining at stools was noticeable and stools contained only dark brown fluid and mucus. It was not until operation had been performed that her mentally deficient father recalled that she had passed a few round worms about three weeks previously.

Physical Examination: A well developed and well nourished colored female about three years of age, lying on examining table, apparently very ill and irritable with periodic (every 2 to 3 minutes) outcrys suggesting pain of a spasmodic character. Temperature 99° F. by axilla, pulse 100. No deformities or other acquired or congenital stigmata present. Head, heart, and lungs clear.

Abdomen moderately distended and tympanitic. Muscles were somewhat tense but could be controlled by suggestion and gentle stroking, after which palpation could be done with fair ease. There was a firm, freely movable mass, the circumference of which was that of a large orange, and the length about eight inches. It extended from about four inches above to about four inches below and to the right of the umbilicus. Manipulation of mass caused very little discomfort. Rectal examination revealed a large, firm, freely movable and only slightly tender mass which started in right iliac fossa and extended upward.

Laboratory: Admission blood count: W. b. c., 17,850; polys., 77 per cent; lymphocytes, 19 per

cent; transitionals, 2 per cent; eosinophiles, 1 per cent; basophiles, 1 per cent.

Preoperative Diagnosis: Intestinal obstruction. As a causative factor, intussusception and Meckel's diverticulitis were given as the most likely possibilities. Impaction by round worms was mentioned, but given little credence.

Operation: A long mid-right rectus incision was made. As soon as the peritoneum was opened, the mass fell into the wound and an entangled mass of round worms was visible through the gut wall. Blood supply to gut was still fairly free and the gut wall was in recoverable condition except for a spot about the size of a dime. The mass started about eight inches above ileo-cecal valve and extended upward. The appendix was elongated, injected and inflamed. A small quantity of clear brownish fluid was recovered from the peritoneal cavity. The mass was delivered, an opening made in wall of gut and worms removed. After closing opening, another smaller mass was discovered about 10 inches above larger mass and gut wall was again opened and worms removed. Eighty-four large round worms from 6 to 14 inches in length were recovered. A large hard rubber catheter was inserted into ileum about 10 inches above valve, retained by two purse-string sutures,

Mass of Round Worms Causing Obstruction of the Intestine.

and anchored to parietal peritoneum at lower angle of incision. Incision closed in layers without drain in peritoneal cavity.

Postoperative Care and Course: Beginning on first postoperative day, when the temperature was 101.6° F. by axilla, there was a gradual decline, temperature never again going above 100° F., and by the end of the fifth day and for the remainder of the convalescence period there was no fever. Her general condition followed the temperature curve. There was considerable restlessness for first week. The abdomen was perfectly soft from the beginning. During the first two weeks the ileostomy opening drained profusely soft fecal material and worm fragments well diluted with fluid. During third week opening drained only slightly and by the end of the third week opening had ceased to drain at all.

After beginning of second week bowels started moving from below, she took plenty of nourishment, became playful, and rapid recovery was evident. During latter part of third week urine showed only occasional pus cells in a voided specimen; Rbc., 5,580,000; Hb. 100 per cent (Tallquist).

Kahn test on blood was unsatisfactory. She was discharged into the hands of the family physician on the twenty-sixth day in excellent condition.

VICKSBURG SANITARIUM AND CRAWFORD STREET HOSPITAL.

Staff Meeting—August 10, 1931.

Abstract: Carcinoma of the Stomach—Dr. A. Street.

Patient: White, female, age 59, married, two children; admitted to hospital July 15, 1931.

Present Illness: Since having a bad spell of influenza four months ago, patient has been having afternoon temperature, 99 to 100° F., and failing in strength. She has lost 43 pounds in weight (from 183 to 140). Appetite very poor; no nausea; severe pain in left abdomen about the level of the umbilicus and occurring promptly after eating. This pain is often precipitated by a drink of water. There is no other pain than as above described. Bowels normal; sleeps well; no bladder disturbance; slight dyspnea on exertion; no cough; no tar stools. She thinks she notices a lump in the left abdomen at times.

Physical Examination: Temp., 99.8° F.; blood pressure, systolic, 135. Well developed and nourished; skin, rather pale; teeth, false; tongue, slightly fissured and the middle third very red but not smooth. Abdominal examination shows no masses and no tenderness. Physical examination otherwise not remarkable.

Urine: Sp. gr., 1.023; slight trace of albumin; few fresh red blood cells.

Blood: Hb., 62 per cent; erythrocytes, 4,200,000; leukocytes, 9,200; small lymphocytes, 7 per cent; large lymph., 1 per cent; monocytes, 6 per cent; polym. neutrophiles, 83 per cent; polym.

eosinophiles, 2 per cent; polym. basophiles, 1 per cent. Wassermann, Kline and Young, and Kahn tests negative.

Fractional gastric analysis showed no free HCl; much mucus, lactic acid, a trace of chemical blood and microscopically a few fresh red blood cells. Blood urea nitrogen was 28 mg. per 100 cc.; blood sugar 83 mg. per 100 cc.

Fluoroscopic and radiographic examinations showed a large mass in the central portion of the stomach, giving rise to a large, irregular filling defect. Roentgen-ray diagnosis: carcinoma of the stomach.

Procedure: Exploration was advised in order to see whether or not the growth was operable and to remove it if operable. The stomach was lavaged each morning for seven days prior to date of operation, and the patient was fed bland soft food in small amounts and at frequent intervals. A suitable donor for transfusion was obtained and was present shortly before the time set for operation. The patient was taken to the operating room with the duodenal tube in the stomach. Before beginning the operation, the stomach was washed and one ounce of 1 per cent acriflavine solution injected into the stomach.

Operation, July 23, 1931: Spinal anesthesia; a very high right hand paramedian incision. The distal half of the stomach is invaded by a large, hard, nodular growth. The anterior surface is free; the posterior surface is fixed. There are large glands in the gastro-colic and gastro-hepatic omenta. The liver is not apparently involved. The fixation of the posterior surface made operability questionable, but palpation of the pancreas showed it free of induration and resection was decided upon. After ligating and dividing the blood vessels on the greater and lesser curvatures, the stomach was divided proximal to the growth. The condition on the posterior wall could then be observed much more accurately than before. As the stomach was rather low, part of it was in relation posteriorly to the mesocolon and masocolon was invaded. One of the branches of the middle colic artery was within this portion. A temporary clamp was placed on this arterial branch, and the transverse colon carefully observed. It was finally decided that blood supply was not impaired and the artery was then divided and ligated and the involved portion of mesocolon resected. In doing this, a perforation was uncovered which allowed the escape of gas and some of the flavine colored content of the stomach. The granulating floor of the perforation was carefully removed. The remainder of the mobilization was quite easy; the duodenum was divided and the stump inverted. The proximal jejunum was drawn through the opening which was made when part of the mesocolon was resected, and the entire end of the stomach was anastomosed to the side of the jejunum (Polya operation). The margins of the opening in the mesocolon were then stitched to the stomach just proximal to the line of anastomosis. The peritoneum was closed and a small drain placed in the abdominal wall. A transfusion of 600 c.c. of citrated blood was given during the operation. The duodenal tube was left in the stomach.

Subsequent: The patient's convalescence has been uneventful. She eats without discomfort and is to return home in a few days. There was some abdominal wall infection, but at no time was there abdominal distention or other evidence of peritoneal infection.

Tissue examination by Dr. Lippincott showed adeno-carcinoma (Group IV), with much ulceration. At site of perforation posterior growth extends through wall and into adherent fatty tissue. Two lymph nodes examined showing hyperplasia and chronic inflammatory changes but no cancer.

Abstract: Brain Tumor—Dr. J. A. K. Birchett, Jr.

Patient: Colored, male, aged 28, former dining car waiter.

Chief Complaint: Headache, nervous spells, vomiting.

Present History: About six months ago began having headaches and dizzy spells; four months ago first noticed nervousness; unable to write or concentrate on any work, head and hands would tremble. Any excitement or prolonged conversation will precipitate coarse tremor of head. Complains of headache and after it develops will have severe vomiting which relieves condition for an hour or two. Then has tremor, headache and vomiting again. These phenomena have occurred as many as a dozen times a day. No loss of consciousness. At times not able to see well. There has been no marked loss of weight although there has been some steadily increasing weakness. No fever or chills. No evidence of any loss of muscle function; hearing normal.

Physical Examination: Temp., 98° F.; pulse, 60, full; blood pressure, 120/80; respiration, 18. Well developed and nourished. Eyes very prominent; no marked nystagmus; pupils react to light and accommodation. Examination of eye grounds under atropin showed marked bilateral choked disc. Knee jerks exaggerated. Spinal puncture showed fluid under markedly increased pressure and probably 60 c.c. of fluid escaped. Physical findings were otherwise essentially negative.

Blood Wassermann, Kline and Young and Kahn tests negative; spinal fluid Wassermann test and

colloidal gold test, negative. Blood and urine showed nothing remarkable.

Diagnosis: From history and physical findings, we think of brain tumor as the cause of the symptoms, but other diseases giving the same or similar symptoms and to be ruled out are nephritis, lead poisoning, multiple sclerosis, epilepsy, paretic dementia, abscess and gumma. The diagnosis of brain tumor is based chiefly on the evidence of choked discs, constant headache of varying intensity and especially increased by excitement or exertion, vomiting which is always a valuable sign and when present usually follows headache and is projectile in character, slow pulse, vertigo, and epilepsy of Jacksonian type.

In this case, the decidedly increased spinal fluid pressure, choked discs, the appearance of the sella tursica in the roentgen-ray plate, and the train of symptoms of headache, vomiting and eye disturbance suggest that the tumor is in the region of the hypophysis, although there is no evidence of the usual signs of perversion of the pituitary body secretions. This can be explained by the comparatively recent development of the tumor, which up to this time has apparently not interfered with pituitary secretions. The roentgen-ray in this case suggests a sarcomatous change with fragmentation and destruction of the clinoid process.

Abstract: Osteomyelitis, Acute.—Dr. G. C. Jarratt.

Patient: White, female infant, aged 2 years, 4 months; admitted to hospital June 11, 1931.

Chief Complaint: Fever; convulsions; pain and swelling of left leg.

Present Illness: Mother states that ten days ago child was taken ill with temperature of 105° F. Physician was called and pronounced the condition tonsilitis. Some fever the next day but was well up to four days ago, at which time she began to limp when walking. Fever then arose to high level and has been present since. At the same time swelling was noted in left lower extremity from knee to hip but most marked at knee joint. When attempt was made to move leg, child cried out with pain. Tonight about 10:30 o'clock, child had fever of 105.5° F., and generalized convulsions that lasted for two to three minutes. Another convulsion occurred at 11 P. M., lasting about two minutes. Has then been asleep since last convulsion and slept on trip to hospital (arrived about 2 A. M.).

Past History: No illness of any consequence except frequent attacks of tonsilitis.

Physical Examination: Temperature 105.6° F.; Blood pressure 130-90. Well developed and nourished; very acutely ill; drowsy but can be aroused.

Head: Not remarkable; pupils equal and react to light and accommodation; ears normal; nose normal; 16 milk teeth; no membranes or Koplik's spots; tonsils moderately enlarged but not inflamed. Neck: no glandular enlargement; no stiffness present. Chest: expansion good and equal; no rales, bronchophony or impaired resonance. Heart: no murmurs or enlargement. Abdomen: soft and flat; spleen and liver not palpable; no masses or tenderness. Genitalia: no discharge. Skin; no rash or petechiae; several areas of impetigo on chin. Central Nervous System: negative Babinski, Brudinski, and ankle clonus; knee jerks normal; Chvostek's and Trousseau's signs negative.

Extremities: upper and right lower normal. Left lower: there is marked swelling of left thigh from knee to junction of middle and upper thirds, increased heat, redness, and is very painful to touch or movement; no swelling of lower portion of knee joint; no areas of fluctuation; swelling seems deep.

On June 11, blood showed leukocytes, 41,500; polym. neutrophiles 83 per cent; no malaria found. Urine: slight trace of albumin; granular and hyaline casts and few fresh red blood cells. Roentgen-ray examination of left femur was negative.

Diagnosis: Osteomyelitis, acute, of left femur; septicemia; acute hemorrhagic nephritis.

Procedure: Child was taken to operating room and incision made along the middle and lower thirds of left femur on dorsal surface; dissection through muscles. Upon separating muscle bellies, there was a gush of about one-half pint of pus. The periostem had been dissected from the bone. Small holes were made through the shaft of the femur with electric drill, along middle and lower thirds. The wound was packed with vaseline gauze and splint applied to thigh and leg. Glucose solution 10 per cent, 150 c.c. was given intravenously.

Cultures of pus showed Staphylococcus aureus.

June 12: Blood pressure 120/80; temp. 104.4° F. Spent a restless night and was very toxic. On night of June 12, noted redness and swelling of middle phalanx of left ring finger; very painful. Diagnosis. osteomyelitis, acute.

June 13: Blood pressure 124/80; temp. 104° F. Blood: leukocytes 14,700. Urine: slight trace of albumin; no casts or blood.

Incision made on dorsum of middle phalanx of left finger; pus found beneath the periosteum. Culture showed Staphylococcus aureus.

June 15: Temperature 101.4° F. Child refusing nourishment and 200 c.c. of whole citrated blood given intravenously. Blood culture taken at this time showed Staphylococcus aureus and Streptococcus viridans.

Subsequently child's temperature remained around 100 to 101° F., she began eating and there was profuse drainage from femur and finger. Discharged from hospital on June 22, with negative urine, and eating well.

Since then child has remained free of fever and gained in weight. Femur still has some discharge. Roentgen-ray reveals good involucrum forming with very little destruction of shaft of femur.

Abstract: Melanoma.—Dr. Walter E. Johnston.

Patient: Colored, female, aged 31, widow; first seen at home July 8, 1931.

Chief Complain: Weakness, loss of weight, and sore on forearm.

Present Illness: Since birth patient has had a small mole, about half the size of a pea, on her right forearm. In December, 1930, while sweeping, she brushed her arm against a sharp nail. The nail penetrated the skin near the base of the mole. In several weeks a small black growth appeared at the site or the wound. This was treated with castor oil until February, 1931, at which time she consulted a physician who "burnt the growth off." For about a month following this the wound healed very slowly. She states that it was almost well when she accidentally struck it again. Around the first of June she noticed a large knot in the right axilla. This has gradually enlarged until it interferes with movement of the arm. During the present illness she has had anorexia and has lost weight rapidly. She has become very weak and nervous. In the last few weeks she has rapidly grown worse. At the present time she is unable to feed herself and has probably lost 20 to 30 pounds of weight.

Family and Past History: Essentially negative.

Physical Examination: Weight 123 lbs.; temperature 99° F.; pulse 130; resp. 30; blood pressure 110/80. Fairly well developed but poorly nourished; skin dry and shows signs of recent loss of weight. Slight general glandular enlargement. The most striking finding in the entire physical examination is the enlarged lymph glands in the right avillary and supraclavicular regions. The nodes in the axillary region form a mass about the size of a lemon while those in the supraclavicular region are as large as an orange, very firmly fixed and almost bonelike in consistency.

Head, eyes, nose, mouth, and ears negative; marked enlargement of both lobes of thyroid; lungs, heart, abdomen, and pelvis negative; on dorsum of right forearm a smooth, skiny, firm black mass is seen, about 3 cm. in diameter.

Urine negative; Wassermann test positive; biopsy and tissue examination shows melanoma.

Discussion: The melanomata derive their name from their characteristic color which is due to the brownish or yellowish pigment contained in the utmor cells. The tumor occurs chiefly in the skin or in the subcutaneous tissue, but is also found in the choroid of the eye, the iris and conjunctiva, on the mucous membrane of the pharynx and rectum, and in the central nervous system. No portion of the surface of the body is entirely exempt from melanomata, but they are relatively frequent on the plantar aspect of the feet and toes, also on the extremities and on the face.

The melanotic tumors are among the most malignant forms known and not only involve the lymph nodes very early but also invade the blood vessels and form metastases throughout the body, enormous masses occurring especially in the liver, also in the pleural, pericardial, and peritoneal cavities, and especially the bladder. They are fortunately rather rare, forming only about one-half of one per cent of malignant growths.

Macroscopically the tumors are interesting in showing a great variation in the amount of pigment. The primary tumor and its metastasses may be coal black. The tumor may be mottled brown and white or may contain only a few dark areas. The metastasis from a perfectly black tumor may be white or metastasis from a light tumor may be intensily pigmented. The nature of the pigment is not fully understood.

Microscopically the early metastases resemble very closely the tissue from which they have been derived, that is, they are found to contain small masses of oval or spherical cells with large vesicular nuclei, sometimes double. These cells may or may not be separated from each other by connective tissue. About and among them may be scattered pigmented connective tissue cells.

Treatment: Removal of all pigmented moles. It is perhaps over emphasized, but it should be remembered that it is possible for these types of moles to become malignant. Therefore, whenever a mole is subject to constant irritation, it should be removed. The frequency of involvement of regional lymph glands in malignant melanoma of the skin and instances of patients surviving 10 years after removal of the glands, confirms the desirability of attacking the glands along with the primary treatment. These types of tumors are but little affected by radiation. Wide distribution often follows the application and the same is true of the results of caustics, fulguration and freezing. Surgery, therefore, is the only treatment for melanotic tumors, and the excision must be early and wide and must include the regional lymph nodes.

LOUISIANA STATE ME DICAL SOCIETY NEWS

H. Theodore Simon, M. D., Associate Editor.

SPECIAL NOTICE.

There is considerable demand for back numbers of the Journal previous to the year 1855. The Journal would respectfully ask that anyone having these back numbers send them to this office at once.

AVOYELLES PARISH MEDICAL SOCIETY.

Head of State Doctors, A Friend to His Profession. Dr. S. C. Barrow, President of State Medicos Makes Timely Talk to Avoyelles Medical Society.

(Reprint of Weekly News, Marksville, La., August 1, 1931).

The Avoyelles Parish Medical Society held its quarterly meeting and "Annual Ladies Meet" at Marksville, Wednesday night, July 22. The wives of the local members, including Mrs. S. C. Barrow of Shreveport and Mrs. J. H. Landrum as guests joined in the dinner at the Mayer's Hotel, after which they were entertained to a Movie Show at the Palace Theater, while the doctors repaired to the Court Building where they held a short program followed by an address given them by Dr. S. C. Barrow, eminent Radiologist of Shreveport and President of the State Medical Association. Besides Dr. Barrow, Dr. J. H. Landrum, Councillor from the Eighth District and Dr. Gordon Morgan of Melville were guests at the meeting. Dr. R. G. Ducote, President, presided. The following members of the Avoyelles unit answered the roll call: Drs. Emil Regard, K. A. Roy, W. F. Couvillon, S. J. Couvillon, Sylvin de'Nux, A. M. Haas, W. A. Quirk, H. C. Jones, A. T. Barbin, L. D. Lafargue, J. L. Pittman and R. G. Ducote.

Dr. Barrow's address was a masterpiece of language and thought, proved very timely and from the expressions of the local physicians in attendance, it's evident that his talk was the most appropriate that was ever delivered along medical lines in Avoyelles parish. While space limitations prevent all what the Doctor had to say, yet this paper takes pleasure to quote the "high lights" of his address with the hope that the physicians of the country, as well as the public generally will take heed to the Doctor's advice and warnings. The distinguished guest's speech was lead by Dr. Walter Couvillon in discussion, followed by Drs. Emil Regard, de'Nux, Sam Couvillon, Haas, Pittman. Landrum and Morgan.

Dr. Farrow discussed "Medical Organization and Medical Economics" and began by complimenting the Avoyelles medicos for their activities and numbered the local unit among the "seventh most active medical organization in the State, as well as the recognized oldest rural medical society in Louisiana." He stressed strongly "to continue to remain well organized" and pointed out that in those parishes where a small number of physicians resided, he had advised that they join the District Society.

The problem of "Medical Economics" was very much emphasized by the Doctor. "The time has come when tradition has to be violated and the question of finances discussed" he argued and "where comes the evil of discussing finances when the great teacher of man discussed monetary problems in many of his parables and in none did he teach other than that the honest and ethical manner of distributing or acquiring money was a sin?" "Creeping in from all angles, insidiously and relentlessly, the Doctor's source of income is being trimmed while we sit supinely by, living upon tradition." This however, as Dr. Barrow explained does not mean that the "time honored and sacred relationship existing between the Doctor and Patient by which their professional and business arrangements are mutually satisfactory, must be disturbed."

The "indigent sick" he pointed out "is a State and Community problem and should be met by the whole community and not any longer be shunted to the shoulders of the Medical Profession." "During our recent catastrophies, droughts and overflows in Louisiana, the indigent people were safeguarded by the Red Cross Society, Health Units and other Governmental agencies. During rehabilitation days the calls on local merchants to feed and clothe those poor unfortunates, as well as the replacement of homes, stock and the care thereof, were made good financially by those agencies throughout the ordeals, but when those poor people became sick, although it's a matter of fact that the doctors of the country always contributed their share or more in support of all local, State and National charitable institutions, the Doctor is made to donate his only commodity, free medical and surgical service."

This, as the Doctor argued is "fundamentally, economically, logically, morally and in every other way wrong, though in line with what some would term Tradition." "When the profession learns to be a little more deliberate in running up the flag 'No Charge' in matters of medical service, where the whole community, the State, the Nation or their subdivisions owe the obligation, the problem at issue will become much easier to solve."

"The practice of our profession is our business and is virtually our only means of making an honorable living and deep in the hearts of every conscientious physician he knows this statement to be true." "He who is afraid of criticism when he knows he is right, lacks manhood and such a trend can be changed only by perfect medical organization and co-ordinated efforts so essential to our welfare and so shining an example to posterity."

Secretary's Note: Dr. Barrow's talk incited such keen interest with the medical men of Avoyelles parish, it became necessary to secure stenographic notes and have the "essential excerpts" of his address published in a local newspaper. The talk was altogether in order and touched the hearts of every doctor present. From the expressions revealed in the discussions, it was conclusively proven that the Doctor touched the keynote and what he said was true. His attitude on this all important subject should be upheld by the profession of this State—a phase in our business so grossly neglected.

S. J. Couvillon, M. D.,
Secretary Avoyelles Parish Medical Society.

BI-PARISH MEDICAL SOCIETY.

The Bi-Parish Medical Society met in the East Louisiana State Hospital as the guests of Superintendent Glen J. Smith and Staff.

After a most enjoyable banquet in the spacious dining room of the institution, the Society went as a body to the Parker Hospital operating rooms to be entertained and enlightened by a most scientific address by Dr. Tom Spec Jones of Baton Rouge, on "The Injection Treatment of Hemorrhoids." After the address Dr. Jones demonstrated the simple technique on two patients of the Hospital.

These injections may be performed in your office without hospitalization of your patient.

A vote of thanks was tendered Dr. Jones for his instructive discourse and practical demonstration to the physicians present. We extended a cordial invitation to the physicians of the States of Louisiana and Mississippi to be our guests at our regular Bi-Monthly meeting, the first Wednesday at 7:30 p. m., every other month. Our next meeting will be in the East Louisiana State Hospital, October, 1931.

DR. ROBERT G. DOUGLAS.

The many friends of Dr. Robert Gibbs Douglas of Shreveport were shocked to hear of his death July 23, following several weeks' illness. Dr. Douglas was born in 1885, and graduated from Tulane Medical School in 1919. Almost since the time of his graduation he has been connected with the Highland Clinic, where he devoted himself solely to internal medicine.

Dr. Douglas took an active interest in organized medicine. He was a regular attendant at the meetings of the State Medical Society, participated actively in the work of the Section on Medicine and Therapeutics, having presented several papers for this Section. He had been selected as Chairman of the Section on Medicine and Therapeutics for next year by Dr. Barrow. In the Shreveport Medical Society Dr. Douglas was likewise active, and his ability as a medical man and his charming personality resulted in his being elected President of the Shreveport Medical Society. Dr. Douglas was also Chairman of the Caddo Parish Citizens' Health Committee, directing and handling the anti-malaria campaign.

DR. H. T. NICHOLLE.

Dr. C. A. Weiss of Baton Rouge has sent to the Journal the following obituary of Dr. H. T. Nicholle, who died suddenly Monday, August 3, following a cerebral hemorrhage.

Henry Teche Nicholle was born at Convent, Louisiana, in 1882, and received his medical education at Tulane University Medical School, receiving his degree in 1908. Prior to his graduation he served as an Interne at Charity Hospital for two years. After his graduation he specialized in bacteriology and pathology, in which field he made rapid strides and was recognized for his accomplishments.

During the World War he served with distinction, being promoted several times; his final promotion being to that of Major.

After his service with the American Expeditionary Forces, he was sent into Germany with the Army of Occupation.

Six years ago he came to Baton Rouge as Bacteriologist and Pathologist at Our Lady of the Lake Sanitarium, where he soon gave evidence of his ability and his pre-eminent knowledge of

bacteriology and pathology. Under his guidance this department reached a high degree of efficiency.

One of the outstanding accomplishments was his organization of the monthly Clinical-Pathological Conferences of Our Lady of the Lake Sanitarium.

His associates will speak of his professional attainments, will tell of his ability. Notable as was his ability in his chosen and beloved profession, even greater was his capacity for friendship, his passion for service.

To his bereaved family we offer our deepest sympathy and assurance that the memory of his friendship and his kindliness of heart will endure.

MORBIDITY WEEKLY REPORT.

Dr. J. A. O'Hara, in collaboration with the United States Public Health Service, of the Treasury Department, has issued weekly morbidity reports from Louisiana which are abstracted briefly below.

During the week ending July 18, the outstanding illnesses reported have to do with pellegra and syphilis. Of the former, 325 cases were reported, and of the latter 173. For the week ending July 25, pneumonia led all other reportable diseases, 77 being reported, and followed in order by syphilis 73, pulmonary tuberculosis 63, typhoid fever 48, and pellegra 42. For the week ending August 1, the reportable pneumonia cases had fallen to 49 and tuberculosis to 32. Syphilis had increased to 95 cases and typhoid fever to 73, 35 of which were reported in the Parish of Orleans and 32 of these were "imported" cases going to the Charity Hospital. For the week ending August 8, 50 cases of pulmonary tuberculosis were reported, 52 cases of syphilis, 70 cases of typhoid fever, and 35 cases of pneumonia. Of the typhoid fever cases, 16 came from the City of New Orleans, again a majority being "imported" cases, and 10 came from the Parish of West Carroll. Diphtheria, scarlet fever, small pox, and other contagious diseases were reported only in a very small number. The same statement holds true for these diseases in the morbidity weekly reports for the week ending August 15. There were, however, 50 cases of typhoid reported, 10 from the Parish of Caddo, 6 from West Carroll, and 7 from Avoyelles. During this week there were only 11 cases of pellegra reported, 26 cases of pulmonary tuberculosis, and 20 cases of pneumonia while 59 cases of syphilis were reported.

POST GRADUATE INSTRUCTION.

The New York Academy of Medicine has sent out circulars describing their fourth annual graduate fortnight of instruction. The two weeks' course that has been arranged seems most attractive. There will be clinics and lectures devoted primarily to disorders of the circulation, but in addition to this course there will also be given at the Mount Sinia Hospital additional lectures, including the two Janeway lectures, both of which will be given by Sir Thomas Lewis of London. The programs and the information concerning registration for this course are on file in the Journal office.

HEALTH OF NEW ORLEANS.

The Division of Vital Statistics of the United States Department of Commerce has reported for the week ending August 1, 1931, that there were 122 deaths in the City of New Orleans, giving the low death rate of 13.6. Sixty-seven of these deaths occurred in the white and 55 among the colored race. For the week ending August 8, there were 128 deaths in the City of New Orleans, 78 among the white, and 50 among the colored, giving the death rate of 14.3. Thirteen of these deaths were in children under one year of age. The number of deaths and the proportion among the two races during this week was practically the same as the corresponding week of 1930.

NEWS ITEMS.

President S. C. Barrow spent Friday, August 21, in New Orleans for the purpose of going over official State business with Secretary-Treasurer Talbot. Dr. Barrow also attended the Journal Committee held at 7:30 P. M. the same day.

Dr. Leon J. Menville has been elected an honorary member of the "Pi Gamma Mu," National Social Science Honor Society.

MISSISSIPPI STATE MEDICAL ASSOCIATION NEWS

L. S. Lippincott, Editor
Jacob S. Ullman, Associate Editor *D. W. Jones, Associate Editor*

THAT WE MAY KNOW EACH OTHER BETTER.

Dr. Clyde Madison Speck, New Albany, Vice-President of the Mississippi State Medical Association, was born July 22, 1887, at Blue Springs, the son of P. M. and Dona A. Speck. He attended Mississippi Heights Academy and received his degree in medicine from the Vanderbilt University Medical Department in 1912. He was licensed to practice medicine in Mississippi in 1910. Dr. Speck married Carrie C. Mayes, January 31, 1916, and has one daughter, Carolyn, born March 31, 1921.

CLYDE MADISON SPECK, M. D.
New Albany, Miss.
Vice-President, Mississippi State Medical Association.

Dr. Speck first engaged in medical practice at Blue Springs where he remained until 1917, then entering the medical department of the Army, as a First Lieutenant. He served in succession at El Paso, Texas, with the 10th Field Hospital, at the Base Hospital at Fort Sam Houston, at Camp Newton D. Baker, San Antonio, at Camp Tarvis, El Paso, and as Commanding Officer of Ambulance Company, No. 72 with the 18th Division. He received his discharge from the Army in 1918.

Dr. Speck returned to general practice at New Albany and was connected with the Mayes Hospital as assistant surgeon until 1927 when he organized the New Albany Hospital and Clinic, Inc., and was elected secretary. He is physician and surgeon, United States Bureau of Pensions, a member of the Northeast Mississippi Thirteen Counties Medical Society, the Mississippi State Medical Association, Southern Medical Association and a fellow of the American Medical Association. He was this year elected secretary and treasurer of the Mississippi State Hospital Association and is field examiner for the Veterans Bureau for the State of Mississippi. He is a Mason and a Shriner and a member of the Kiwanis Club of New Albany.

CALENDAR.

September 1: Claiborne County Medical Society, 3 p. m.; Staff of King's Daughters' Hospital, Brookhaven, 7:30 p. m.

September 2: Staff Hospital, Natchez; Staff of Vicksburg Infirmary, Vicksburg, 7:30 p. m.; Staff of Rush's Infirmary, Meridian, 7 p. m.; Staff of Dr. F. G. Riley's Children and Maternity Hospital and Clinic, Meridian, 7 p. m.

September 3: Pike County Medical Society, McComb, 7:30 p. m.

September 4: Natchez Medical Club, 1 p. m.

September 7: Jackson County Medical Society, 7:30 p. m.; Staff of Jackson County Hospital, 7:30 p. m.; Staff of Meridian Sanitarium, 7 p. m.

September 8: Issaquena-Sharkey-Warren Counties Medical Society, Y. M. C. A., Vicksburg, 7 p. m.; Staff of Natchez Sanatorium, 7 p. m.; Tri-County Medical Society, Monticello, 12 noon; Winston County Medical Fraternity, Louisville.

September 9: Staff of King's Daughters' Hospital, Greenville, 7 p. m.

September 10: Staff of Vicksburg Sanitarium, 6:30 p. m.; Staff of Vicksburg Hospital, 7:30 p. m.

September 11: Staff of Anderson Infirmary, Meridian, 7 p. m.

September 15: Staff of Natchez Charity Hospital, 8 p. m.; North East Mississippi Thirteen Counties Medical Society, 2 p. m.

September 18: Natchez Medical Club, 1 p. m.

October 1: Pike County Medical Society, McComb, 7:30 p. m.

October 2: Natchez Medical Club, 1 p. m.

October 5: Staff of Jackson County Hospital, 7:30 p. m.; DeSoto County Medical Society, Hernando, 10 a. m.; Staff of Meridian Sanitarium, 7 p. m.

October 6: Homochitto Valley Medical Society, Natchez, 1 p. m.; Staff of King's Daughters' Hospital, Brookhaven, 7:30 p. m.; Annual Meeting of 8th Councilor District, Natchez.

October 7: Staff of Chamberlain-Rice Hospital, Natchez; Staff of Vicksburg Infirmary, 7:30 p. m.; Staff of Rush's Infirmary, Meridian, 7 p. m.; Staff of Dr. F. G. Riley's Children and Maternity Hospital and Clinic, Meridian, 7 p. m.

October 8: Staff of Vicksburg Hospital, 7:30 p. m.

October 9: Staff of Anderson Infirmary, Meridian, 7 p. m.

October 10: Staff of Vicksburg Sanitarium, 6:30 p. m.

October 13: Issaquena-Sharkey-Warren Counties Medical Society, Y. M. C. A., Vicksburg, 7 p. m.; Staff of Natchez Sanatorium, 7 p. m.; Winston County Medical Fraternity, Louisville.

October 14: Staff of King's Daughters' Hospital, Greenville, 7 p. m.; Delta Medical Society, Moorhead, 2 p. m.

October 15: East Mississippi Medical Society.

October 16: Natchez Medical Club, 1 p. m.

October 20: Staff of Natchez Charity Hospital, 8 p. m.

November 2: Staff of Jackson County Hospital, 7:30 p. m.; Staff of Meridian Sanitarium, 7 p. m.

November 3: Staff of King's Daughters' Hospital, Brookhaven, 7:30 p. m.

November 4: Staff of Chamberlain-Rice Hospital, Natchez; Staff of Vicksburg Infirmary, 7:30 p. m.; Staff of Rush's Infirmary, Meridian, 7 p. m.; Staff of Dr. F. G. Riley's Children and Maternity Hospital and Clinic, Meridian, 7 p. m.; Clarksdale and Six Counties Medical Society, Clarksdale, 7:30 p. m.

November 5: Pike County Medical Society, McComb, 7:30 p. m.

November 6: Natchez Medical Club, 1 p. m.

November 9: Staff of Vicksburg Sanitarium, 6:30 p. m.

November 10: Issaquena-Sharkey-Warren Counties Medical Society, Y. M. C. A., Vicksburg, 7 p. m.; Staff of Natchez Sanatorium, 7 p. m.; Winston County Medical Fraternity, Louisville.

November 11: Staff of King's Daughters' Hospital, Greenville, 7 p. m.

November 12: Staff of Vicksburg Hospital, 7:30 p. m.

November 13: Staff of Anderson Infirmary, Meridian, 7 p. m.

November 17: Staff of Natchez Charity Hospital, 8 p. m.

November 20: Natchez Medical Club, 1 p. m.

December 1: Claiborne County Medical Society, 3 p. m.; Staff of King's Daughters' Hospital, Brookhaven, 7:30 p. m.

December 2: Staff of Chamberlain-Rice Hospital, Natchez, Staff of Vicksburg Infirmary, 7:30 p. m.; Staff of Rush's Infirmary, Meridian, 7 p. m.; Staff of Dr. F. G. Riley's Children and Maternity Hospital and Clinic, Meridian, 7 p. m.

December 3: Pike County Medical Society, McComb, 7:30 p. m.

December 4: Natchez Medical Club, 1 p. m.

December 7: Jackson County Medical Society, 7:30 p. m.; Staff of Meridian Sanitarium, 7 p. m.; Staff of Jackson County Hospital, 7:30 p. m.

December 8: Joint Meeting of the Fifth District Medical Society of Louisiana and the Issaquena-Sharkey-Warren Counties Medical Society, Vicksburg; Staff of Natchez Sanatorium, 7 p. m.; Winston County Medical Fraternity, Louisville.

December 9: Staff of King's Daughters' Hospital, Greenville, 7 p. m.

December 10: Staff of Vicksburg Sanitarium, 6:30 p. m.; Staff of Vicksburg Hospital, 7:30 p. m.

December 11: Staff of Anderson Infirmary, Meridian, 7 p. m.

December 15: Staff of Natchez Charity Hospital, 8 p. m., North East Mississippi Thirteen Counties Medical Society, 2 p. m.

December 17: East Mississippi Medical Society.

December 18: Natchez Medical Club, 1 p. m.

COMMUNITY HOSPITALS.

During the recent political campaign, many of the many candidates stated that they were in favor of providing free beds for poor patients in every county hospital. Their ideas were somewhat at variance as to detail of ways and means.

At the recent meeting of the State Association at Jackson a resolution was adopted which provided for the appointment of a committee "To inform the public on the importance of this problem during the present campaign, in which a governor and members of the legislature are to be selected; to advise with the offer of assistance to our next legislative body in making the proper distribution of the state charity funds for hospitals; and to see that the hospitals measure up to the standards that will provide safety to the public."

This resolution was adopted without discussion and therefore the members of the House of Delegates, and the profession generally, are uninformed as to what is a proper distribution of the state charity funds for hospitals. In such places as Columbus, Hattiesburg, McComb, New Albany, Oxford and Philadelphia there are two hospitals. Does this committee intend to give to both institutions in these towns? Or if to but one how is the distinction to be made? Would it not be well to publish, at an early date, the standards by which the hospitals are to be measured?

The fund provided by the State at the present for the state charity hospitals is about a dollar a day per patient. The cost of caring for the patient in the small hospitals is not less than four dollars per day. Who is going to put up the other three dollars? Is the State to be asked to adopt a plan of caring for its indigent sick that will cost at least four times as much as its present method is costing?

This is not a defense of the state hospitals as at present maintained. In the first place the five state hospitals are located in a belt that extends from the Mississippi river at Vicksburg and Natchez to the eastern border of the state at Meridian and Laurel, thus leaving the whole northern half and the far southern section of the state out of reach in the case of emergencies. Secondly, for the past twenty-five years or more it has been the custom for each new governor to appoint a new board of trustees for each state institution. For many years it has been an accepted fact that the new board would appoint a new superintendent, who must be a surgeon. It is obvious that these constant changes dictated by political motives have interferred with the building up of an adequate staff at these institutions. As a matter of fact, in the majority of cases the superintendent has been more interested in doing surgery than he has been in superintending. It is evident, too, that in a hospital of a hundred beds or more where the superintendent in addition to caring for the business management of the hospital, must eat and sleep, it is a physical impossibility to give proper attention to all of the patients in an institution of this size. And it is equally evident that the direction and supervision of an intern staff without the aid of a visiting staff requires just as much of the superintendent's time as if he were to do the work himself.

On the other hand, it is a well known fact that in efficiently managed hospitals the per capita cost per day decreases as the number of patients cared for increases. At the present time much is being said about the cost of diagnosis and treatment, which has already mounted to an alarming figure. Will these small community hospitals be prepared to make a thorough diagnostic study at a cost that may be born by the average man?

The questions asked above, it seems, should be given long and earnest consideration before the committee presents this matter to the Legislature. These smaller hospitals need aid as much as the five state institutions but unless the medical profession is prepared to offer a plan that will work smoothly and fairly for all hospitals and for the public we are more than likely to have forced on us some ill-considered plan prepared by a layman, which may prove to be another path leading to state medicine.

It is suggested that the Committee on Community Hospitals make a study of this matter before the Legislature meets. Let them study the plans for operating hospitals in Texas and Minnesota. With such data in hand this Committee would be in a position to present a bill to the Legislature that should be of real value. But this is of such importance that no report should be made until a modus operandi that will stand the test of time, and that will be fair both to patients and to physicians, shall have been adopted.

J. S. Ullman.

WE ARE MOST HAPPY TO MAKE THE CORRECTION.

New Orleans Medical and Surgical Journal,
New Orleans, Louisiana.

Dear Sir:—

I notice in the July issue of your Journal that you have me listed among the dead. I would be pleased to know where you got the report that I had passed on. I am very glad to say that I am

still very much alive and on the staff of the South Mississippi Charity Hospital, Laurel, Mississippi.

Very truly,

(Signed) K. R. Commack.

Dr. K. R. Commack,
South Mississippi Charity Hospital,
Laurel, Mississippi.

Dear Dr. Commack:

I am in receipt of a letter from Dr. W. R. Wirth, Editor of the New Orleans Medical and Surgical Journal, enclosing a copy of a letter from you in regard to the reporting in the July number of the Journal the death of Dr. Kossuth R. Commack, Chicora.

The report came to me from the Mississippi State Board of Health.

I am writing to the State Board of Health today that the correction may be made in the records and I shall make the correction in the next number of the Journal. I am certainly delighted to know that the report was not correct.

With all good wishes,

Sincerely yours,

(Signed) Leon S. Lippincott.

cc. to Dr. W. R. Wirth
Dr. F. J. Underwood.

MONROE COUNTY.

No, I am not on a vacation—money too scarce. My stock of energy has been at ebb-tide. My brain has been stupified by the oppressive heat. My secretary has been fully occupied meeting and shunting candidates, county and state. My typewriter does not function automatically. Besides all this, news might be interesting to your readers has been lacking. There have been no deaths, serious sickness nor marriages in the homes of any of our county members.

One thing I might mention is the fact that one of our most deserving and popular members has been given a scholarship in a postgraduate course —namely Dr. B. C. Tubb of Smithville. This scholarship is one of five allotted to Mississippi by a fund in New York. The course is for four months and to be taken at Tulane.

Speaking of vacations I will say that only one of our fraternity in this county has indulged in such a luxury,—namely, Dr. M. Q. Ewing. He is away at present, perhaps at Miami or Savannah. I think he stated that there is nothing doing in his line and that he can live as cheaply one place as another. Really I think the supply of appendices has been exhausted by him, Dr. Philpot and Dr. Kirk of Tupelo. They may have to wait until another crop is grown. However, I discovered one individual in the person of a beautiful young lady who has escaped so far. I advised and persuaded her to hold hers fast for awhile longer, reminding her that the right ureter was in such close proximity to the appendix that not every right abdominal distress was due to a "chronic" appendix. In fact I told her that I had heard one of the nation's surgical authorities express doubt as to there being such an entity as a chronic appendix. I have run out of soap—goodbye.

G. S. Bryan, County Editor.

DR. I. T. WOODRUFF.

Dr. I. T. Woodruff, graduate of Memphis Hospital Medical College, class of 1893, died July 11, at his residence near Courtland. The cause of death was pulmonary tuberculosis, from which he had suffered for about twenty years.

Dr. Woodruff practiced medicine a few years in DeSoto County, but most of his professional career was spent in his native county, Panola, practicing in Courtland, then moving to Batesville several years ago, where he lived until his health failed and he moved to his farm near Courtland.

Dr. Woodruff made numerous friends among his large practice and his death is mourned by all. He leaves a devoted wife, one brother, and several sisters who miss his kindly presence among them.

G. H. Wood, County Editor.

HISTORY OF THE MISSISSIPPI STATE MEDICAL ASSOCIATION (Continued).

Any additions or corrections will be appreciated by the Historian, Dr. E. F. Howard.

1913.—The following year we find the Association preparing to honor a former member who, since leaving Mississippi, had been successful in throwing additional light on a problem peculiarly interesting to the South. Dr. C. C. Bass' recent studies of the malarial parasite and his application of the information thus acquired in the control of the disease had added materially to our knowledge and in recognition of his services the Association voted him a medal, which was presented at the 1914 meeting by Dr. J. S. Ullman.

1914.—At the forty-seventh Annual Session efforts were made to abandon the Insurance Resolutions passed in 1907 and to abolish the defense feature established in 1911, but both rode the storm successfully.

An interesting bit of attempted discipline was shown in the introduction of a motion declaring

vacant the office of Councilor in three districts, for failure in the performance of duty.

A well-deserved tribute was paid the Association's best beloved member by electing Dr. H. L. Sutherland of Rosedale an honorary member, the first to be so honored.

1915.—The 1915 Annual Session, held in Hattiesburg, is chiefly of note in that then was first agitated the question of a State Hospital for tuberculous patients. A general committee was appointed to present the matter to the Legislature and given full authority to invoke the support of the Association, through the county societies.

An interesting example of the power of organized medicine is shown in the reports of the Council. The Secretary of the Southern Medical Association had been extremely lax in the matter of requirements for membership in that body, accepting Mississippi physicians who were not members of the State Association. Complaint having been filed, the Southern's Secretary admitted jurisdiction of the State Council and, proof having been made, agreed to comply with regulations in future.

The chief attraction of this meeting was the presence of Dr. Rudolph Matas of New Orleans who appeared before the surgical section and also delivered the oration, choosing as his subject one on which he was eminently qualified to speak: "The Soul of the Surgeon."

LOWNDES COUNTY.

Dr. C. E. Lehmberg, Captain, Medical Department, 178th Field Artillery, has just returned from encampment at Camp Knox, Kentucky.

Dr. E. Q. Withers and wife are enjoying a vacation on the Caribbean Sea. Dr. Withers is eye, ear, and throat man of the Fite Hospital staff.

Dr. John E. Davis left a few days ago for New York City where he expects to combine business with pleasure.

Dr. Eli Staton of the Columbus Hospital staff has returned with Mrs. Staton from a pleasant vacation.

The North East Mississippi medical men are proud of the selection of Dr. J. M. Acker of Aberdeen to be president of the Mississippi Medical Association and predict for him a most creditable administration.

J. W. Lipscomb, County Editor.

PIKE COUNTY.

Dr. L. D. Dickerson, proprietor and manager of the McComb City Hospital, died June 4, last. Immediately following the death of Dr. Dickerson, Mrs. Dickerson, even with her grief-laden heart, took over the management of the hospital, and while no one could fill Dr. Dickerson's place in the hospital any more than they could fill his place in his church, and in the community, she has certainly caused harmony and good fellowship among the doctors connected with the hospital, and among the patrons of the hospital, to be the ruling "Keystone."

Dr. R. H. Brumfield, our very efficient Secretary of the Pike County Medical Society, will leave August 6, for Rochester, Minn., where he will spend the next three or four weeks attending the Mayo Clinic.

The June meeting of the Pike County Medical Society would have been on Thursday, June 4, but as this was the day that Dr. L. D. Dickerson died, the President had the Secretary call the meeting off. The membership roll still represents 100 per cent of the practicing physicians of Pike County. We have 24 active members in the Society. At the July meeting, which was held on July 2, there were present, 21 members. This, of course, included the two new members who joined the Society that night. Of course, we don't have as large attendance at every meeting, yet I think we still hold the Blue Ribbon for membership roll percentage and for attendance average.

The Pike County Health Unit, under the supervision of the "Commonwealth Fund" and with Dr. T. Paul Haney as director, opened for business on July 1, with headquarters at McComb, and offices on the second floor of the city hall.

Everyone is expecting the health unit to accomplish great good, and they should if they get the right sort of co-operation from the doctors of Pike County, and they will get it—if they give that kind, and I am sure they will. The doctors of Pike County are just that kind of fellows, finest set of men to be found anywhere.

You know, if one will watch as one goes along through life, one will find, with possibly a few exceptions, that one usually gets back just about the kind that one gives out.

I. E. Stennis,
President, Pike County Medical Society.

PONTOTOC COUNTY.

Dr. W. R. Card of Heth, Arkansas, has recently moved to Pontotoc County and is located at Houlka, Route 5.

R. P. Donaldson, County Editor.

BOLIVAR COUNTY HEALTH DEPARTMENT.

Dr. L. B. Austin, member of the Mississippi State Board of Health for the third district, has

recently received the biennial report of the Department of Health of Bolivar County as prepared by Dr. R. D. Dedwylder, Director.

The report contains some very interesting information in regard to the County, its location and natural advantages, population and distribution, race proportions, industries, drainage, roads, educational advantages, and enrollment in schools.

The Bolivar County Health Department was organized in July 1920, and has been well supported. At present the staff consists of the Director, Dr. Dedwylder, two nurses, bacteriologist, technician, inspector, part time engineer, and a nurse and inspector paid for by the United States Public Health Service. Due to economic conditions, anti-mosquito work has been discontinued.

Educational activities for the two years include 441 lectures: public lectures, 91, and school lectures, 350; bulletins distributed, 5,276; newspaper articles published, 89; letters and notices, 4,926; reports of all kinds, 1,506; conferences, 136; other activities, 4,936. The total attendance at lectures was 19,961.

In the control of communicable diseases 610 general examinations were made, 487 visits were made, 7 carriers were isolated and 133 contacts quarantined. For venereal disease, 1,500 suspects were examined and 770 treatments given to indigent cases. A total of 3,486 Schick tests were made of which 841 were positive. Forty Dick tests were made of which 8 were positive. For the control of bovine tuberculosis 957 cows were tested. For immunization 9,147 doses of toxin-antitoxin mixture were given; 55,667 doses of typhoid vaccines were given; 3,729 smallpox vaccinations were made; and 215 doses of anti-rabies vaccine were administered.

The laboratory of the health department is constantly used by all the physicians of the county.

The special anti-malaria campaign which it was necessary to discontinue, included the use of a spot map of malaria foci and the organization of mosquito control work. Screening of tenant rural homes has been urged and 536 recorded houses have been screened and 1,946 standard doors installed. A part time engineering service provides for the promotion of minor drainage. This work is very popular and the call for the services of the engineer is constantly increasing.

VICKSBURG SANITARIUM AND CRAWFORD STREET HOSPITAL.

The regular monthly meeting of the staff of the Vicksburg Sanitarium and Crawford Street Hospital was held on August 10, with nine members of the staff and eight guests present.

After the business of the staff and reports from the records department and analysis of the work of the hospital, the following special reports of current cases were presented:

1. Fylephlebitis with Multiple Liver Abscesses Following Suppurative Appendicitis.—Dr. G. M. Street.
2. Carcinoma of the Stomach.—Dr. A. Street.
3. Brain Tumor.—Dr. J. A. Birchett, Jr.
4. Osteomyelitis, Acute.—Dr. G. C. Jarratt.
5. Melanoma.—Dr. Walter Johnston.

Selected radiographic studies were demonstrated as follows: Pulmonary tuberculosis, cholelithiasis, nephrolithiasis, tumor of kidney.

Drs. S. W. Johnston and Walter Johnston presented a moving picture on spinal anesthesia.

The meeting closed with a lunch.

WINSTON COUNTY.

The Winston County Medical Fraternity meets the second Tuesday night of each month.

Dr. R. L. Donald of Louisville, who came here the first of last month, was mentioned in last locals as having with him a wife. In justice to Dr. Donald we are pleased to correct this mistake, as he is a single man.

Drs. Hickman and Hickman are adding to their office accommodations and preparing to meet any work that may come to them.

Distressingly healthy times in this section are giving the doctors a time to rest and relax.

We notice with disapproval a political reflection on our good servant and friend, Dr. Willis Walley of Jackson. We are not concerned as to his political alignment, but commend him most highly as a surgeon in the capacity he now occupies, superintendent of the State Charity Hospital at Jackson. We have depended upon these institutions to do all of our charity surgery for a period of twenty years, and Dr. Walley has given service second to none.

M. L. Montgomery, County Editor.

ADAMS COUNTY.

Dr. and Mrs. W. K. Stowers are visiting on the Mississippi coast and in Florida.

Dr. J. S. Ullman has returned from a week-end visit to Gulfport.

Dr. H. M. Smith, who for the past month has been at Rochester, Minnesota, for specialized work at the Mayo Clinic, has returned to resume his practice.

L. Wallin, County Editor.

WARREN COUNTY.

Dr. M. H. Bell is enjoying his vacation; his health is improving quite markedly.

Dr. and Mrs. L. J. Clark enjoyed a few days at the Mayo Clinic and in Chicago recently.

Dr. Henry B. Goodman, son of Dr. H. S. Goodman, Cary, is connected with the staff of the Mississippi State Charity Hospital at Vicksburg.

Dr. Nathan Lewis has entered private practice, being associated with Dr. B. B. Martin.

Dr. and Mrs. Preston S. Herring are being congratulated upon the arrival of a little girl.

Edley H. Jones, County Editor.

DEATHS OF MISSISSIPPI PHYSICIANS.

Wilson R. Eatherly, Winterville; diabetes mellitus; July 7, at Winterville. Born Leeville, Tenn., Feb. 14, 1857.

L. L. Greer, McComb; appendicitis; July 11, at McComb. Born Ruth, Dec. 16, 1880.

I. T. Woodruff, Batesville; pulmonary tuberculosis; July 11, at Courtland. Born Panola, Oct. 17, 1870.

Francis V. McRee, Brookhaven; cancer; July 17, at Brookhaven. Born Mississippi, 1871.

William Tillman Duke, Glen Allen; sudden death; July 23, at Galveston, Texas. Born Mississippi, 1890.

James B. Britt, Blue Mountain; heart attack; July 28, at Blue Mountain. Born Clarysville, June 10, 1876.

HOMOCHITTO VALLEY MEDICAL SOCIETY.

On Oct. 6, at Natchez, the Homochitto Valley Medical Society will be host to the Tri-County and Pike County Medical Societies for the meeting of the Eighth Councilor District, which is made up of the counties of Adams, Amite, Copiah, Franklin, Jefferson, Lawrence, Lincoln, Pike, Walthall and Wilkinson.

Drs. Isadore Cohn, New Orleans; T. B. Sellers, New Orleans, and Alphonse H. Meyer, Memphis, are the essayists which assures a program of unusual interest.

Dr. H. M. Smith, Natchez, spent the month of July at the Mayo Clinic, Rochester, Minn., and stopped at Birmingham a few days on his way home to visit the clinic of Dr. Seale Harris.

Dr. J. Dunbar Shields, Pine Ridge, is in the lead as he enters the second primary campaign as candidate for Adams County representative to the State Legislature. J. S. Ullman.

ISSAQUENA-SHARKEY-WARREN COUNTIES MEDICAL SOCIETY.

The regular monthly meeting of the Issaquena-Sharkey-Warren Counties Medical Society was held at the Y. M. C. A., Vicksburg, August 11, with 19 members and 10 guests present. The scientific program included the following:

1. Diphtheria.—Dr. A. K. Barrier, Rolling Fork. Discussed by Drs. F. M. Smith, L. S. Lippincott, E. F. Howard, H. H. Haralson, J. E. Quidor, G. M. Street, all of Vicksburg, and R. H. Foster, Anguilla. Dr. Barrier closed.

2. Nephrolithiasis.—Dr. G. P. Sanderson, Vicksburg. Discussed by Drs. W. H. Parsons and J. A. K. Birchett, Jr., of Vicksburg. Dr. Sanderson closed.

Drs. William Graham Weston, Vicksburg Hospital; Nathan B. Lewis, Vicksburg Infirmary, and Henry Brown Goodman, Mississippi State Charity Hospital, were elected to membership in the society.

Drs. S. W. Johnston and Walter Johnston presented a moving picture, "Spinal Anesthesia."

Drs. M. H. Bell and C. J. Edwards of Vicksburg were reported ill.

The committee, consisting of Drs. W. H. Parsons, Vicksburg; J. B. Benton, Valley Park, and W. C. Pool, Cary, appointed at the last meeting, to investigate the activities of all agencies practicing medicine in the three counties of Issaquena, Sharkey, and Warren, that are financed either in whole or in part from the public funds, in an effort to determine, if, and to what extent these activities are infringing on the rights and just privileges of private physicians, made its report, which included the following:

"The administration of neoarsphenamine, therefore, we consider to be practicing curative medicine. We find that in the Counties of Issaquena and Sharkey the County Health Officer administers this drug upon written order of any physician practicing in those counties. In the year 1930, 541 doses were given. We disapprove of the practice of a county health officer giving this drug and we feel that in this particular instance, the rights and privileges of private physicians are being infringed upon. In justice, however, to the State Board of Health, we must state that the said county health officer of Sharkey and Issaquena Counties gives these injections only upon

written order of a physician of these respective counties. We feel, however, that the State Board of Health should instruct its county health officer to discontinue the administration of neoarsphenamine and we feel that the physicians of Sharkey and Issaquena Counties should discontinue requesting their health officer to give these injections. We have found no instance in Warren County of neoarsphenamine having been given by its health officer.

"Regarding the treatment of pellagra, we are informed by Dr. F. J. Underwood, Dr. A. K. Barrier and Dr. F. Michael Smith that pellagrins are given a diet list and given yeast. We believe this to be practicing curative medicine and we believe this practice to infringe upon the rights and privileges of private physicians. We recommend that the treatment of pellagra be discontinued. We do not, however, wish such recommendation to be construed as opposing educational work in this field.

"We find that school children are examined in all of the three counties and this examination, so far as we have been able to determine, comprises examination of the eyes, ears, throat, heart and lungs and a general survey of the nutrition of the child. If this work is confined strictly to determining if defects exist and in the event they do, recommending to the parents that they consult whatever reputable physician they chose, we see no objection to this practice except that inasmuch as examinations are not thorough, it should be clearly stated to the parents or responsible person that the examination is cursory in nature and does not necessarily mean that there are no defects present.

"We find that in all three counties physical examinations are made of food handlers and of barbers. We recognize the necessity of these examinations being made and approve of this, but we feel that the cost of them if made by private physicians would be in the nature of an occupational tax that would be entirely proper and by no means prohibitive."

The report was adopted and the committee discharged.

The meeting closed with a Dutch lunch.

BOLIVAR COUNTY.

Dr. E. R. Nobles, Rosedale, attended a meeting of the Committee of the Mississippi State Medical Association on Community Hospitals held in Jackson in July.

Dr. S. W. Colquitt, Beulah, spent his vacation in Magnolia, Stamps, and Hope, Arkansas, mingling with relatives and boyhood friends.

Dr. J. E. Williams, Benoit, must have been ill during the month of July as he was absent at one dance. Hope he has recovered.

Dr. C. W. Patterson, Rosedale, was called to the bedside of his mother who is critically ill and not expected to recover.

The next meeting of the Delta Medical Society will be at Moorhead, October 14, at 2 P. M.

C. W. Patterson, County Editor.

PONTOTOC COUNTY.

Beginning July 20, last, Dr. J. R. McCord of Emory University, Atlanta, gave a five day lecture series on the general subject of obstetrics under the direction of the Mississippi State Board of Health, at the Methodist Church, New Albany. Lectures began at two P. M. and lasted until five P. M. In all, twenty-six doctors from the surrounding counties attended. Pontotoc County had three doctors in attendance. They were Dr. Z. A. Dorsey, Troy; Dr. J. H. Windham, Ecru, and Dr. Eliam B. Burns, Ecru. These lectures were concise but comprehensive. They covered normal and pathological obstetrics. This was a very helpful course and will serve to raise the standard of obstetrical practice in this part of the State. We were very fortunate in getting this fine set of lectures from the State Board of Health.

There is no sickness of any consequence among our doctors to report.

Most of us are recovered from the severe attack of "politicitis" which has had us for the last several weeks. Soon we will return to the normal again. Eliam B. Burns, County Editor.

YAZOO COUNTY.

Election is over and everything quiet. Dr. H. L. McCalip, Yazoo City, has just returned from a two weeks' trip with the National Guard at Camp Beauregard, Louisiana.

Drs. Darrington, Swayze, W. D. McCalip, Coker, and Roberts attended the recent joint meeting of the Central Medical Society and the Issaquena-Sharkey-Warren Counties Medical Society at Vicksburg. Had a good time. Dr. John Darrington made a short visit to Dr. Smithson, who is convalescing, we are glad to hear. Hope for a speedy recovery.

C. M. Coker, County Editor.

JACKSON.

Dr. H. R. Shands is taking his vacation in California. At last accounts, he was at Hollywood. We do not know whether he expects to appear in the "movies" or not.

Dr. Frank L. Van Alstine is taking his vacation at Colorado Springs, where he will spend the summer months in recuperating.

Dr. G. C. Russell is taking his vacation at the Mayo Clinic, where he will study some of the newer methods in surgery.

Dr. A. E. Gordin has recently returned from an extensive trip to Cuba and the West Indies, where he was the recipient of many courtesies from officials and doctors.

Dr. J. P. Wall and Miss Sarah King were married on July 25 and left for an extensive tour of European countries. They will visit the former battle fields where Dr. Wall saw service, and Mrs. Wall's relatives in Ireland, where she was born.

Dr. H. R. Hays and Dr. L. W. Long have recently returned from Camp Beauregard, where they attended the officers' training school. They look sunburned and hearty and report that army life in a training camp is a great vacation.

Dr. Brister Ware, University of Mississippi and Jefferson Medical College, who has spent the last two years as an interne in the Louisiana State Charity Hospital, has located here for the practice of general surgery and gynecology. His office is in the Standard Life Building.

Dr. L. V. McCarty, University of Mississippi and Emory University, who spent the last year as an interne at Touro Infirmary, has opened an office in the Standard Life Building, and will engage in general practice.

Dr. Van Dyke Hagaman, University of Mississippi and Vanderbilt, who spent an internship at Crile's Clinic, in ear, nose and throat work, is associated with the State Charity Hospital temporarily.

Several of our doctors are on the sick list. Dr. J. E. McDill is at the Baptist Hospital, undergoing repairs; Dr. L. B. Neal is at home recuperating from an overtaxed heart; Dr. William W. Smithson is at the Jackson Infirmary recuperating after a serious operation.

Mrs. F. E. Werkheiser is at the Willis Walley Hospital very seriously ill but her physicians report some improvement at this writing.

D. W. Jones.

LECTURES ON OBSTETRICS.

By arrangement of the Mississippi State Board of Health with the Children's Bureau of the United States Department of Labor, lecture courses in obstetrics have been made available to the doctors of the State this year. The lectures are given by Dr. James R. McCord, Professor of Obstetrics at Emory University, Atlanta, Ga., and profusely illustrated by slides and remarkably fine motion pictures.

The first course of lectures was given at New Albany, July 20 to 24, with the following in attendance: Drs. E. B. Burns, Ecru; J. I. Mayfield, Blue Mountain; R. B. Cunningham, Booneville; W. C. Hays, Sherman; C. M. Murry, Ripley; S. E. Eason, New Albany; H. P. Boswell, New Albany; R. H. Adams, Ripley; C. M. Speck, New Albany; Frank Ferrell, Ashland; R. A. Holcomb, Hickory Flat; Z. A. Dorsey, Troy; Jessie Mauney, Blue Mountain; W. F. Coleman, Hickory Flat; Joseph J. MacGowan, Ashland; I. B. Trapp, New Albany; J. W. Williams, Ingomar; H. G. Waldrop, Dumas; A. V. Murry, Ripley; E. H. Wesson, New Albany; G. F. Cullens, Wallerville; J. H. Windham, Ecru; T. J. Pennebaker, Cotton Plant; H. A. Stokes, Guntown; J. H. Giles, Ripley; Roy Gilmer Grant, Holly Springs.

The second course of lectures was given at Vicksburg August 3 to 7, with the following in attendance: Drs. H. S. Goodman, Cary; J. S. Ewing, Vicksburg; W. C. Pool, Cary; Felix J. Underwood, Jackson; S. Myers, Vicksburg; J. A. K. Birchett, Vicksburg; M. J. Few, Rolling Fork; C. C. Applewhite, Jackson; A. K. Barrier, Rolling Fork; T. B. Owen, Hollandale; W. P. Shackleford, Hollandale; R. H. Foster, Anguilla; L. Stevens, Tullulah, La.; G. W. Gaines, Tullulah, La.; F. M. Smith, Vicksburg; C. L. Simmons, Hazelhurst; L. S. Lippincott, Vicksburg; J. S. Davidson, Vicksburg; Sidney W. Johnston, Vicksburg; H. B. Goodman, Vicksburg; V. O. Stewart, Anguilla; W. H. Scudder, Mayersville; A. M. Ragan, Edwards; Joseph Whitaker, St. Joseph, La.; E. B. Stribling, Rolling Fork; B. B. Martin, Vicksburg; F. A. Thomas, St. Joseph, La.; N. B. Lewis, Vicksburg; C. F. Clayton, Jr., Vicksburg; C. B. Flinn, Hernando; R. N. Whitfield, Jackson; Preston Herring, Vicksburg; A. T. Palmer, Tullulah, La.; and medical students, D. S. Hall and B. B. Martin, Jr., Vicksburg.

Other courses now planned for Mississippi are in the weeks of August 24, September 28, October 12, November 2, and December 7. If these lectures which really amount to a post-graduate course are successful, it is planned next year to bring to Mississippi a nationally known pediatrician for similar courses. There is no fee to physicians.

The obstetrical lectures cover the following subjects: Monday—Mechanism and Management of

Normal Labor; Management of the Puerperium. Tuesday—The Toxemias of Pregnancy (Eclampsia, Chronic Nephritis); Prenatal Care. Wednesday—Puerperal Sepsis; Syphilis and Pregnancy. Thursday—Breech Presentation; Version; Forceps. Friday—Abortion; Placenta Previa; Accidental Separation of the Placenta.

FELLOWSHIPS AND SCHOLARSHIPS.

The Mississippi State Board of Health has arranged for 15 four months fellowships for practicing physicians of the State. These fellowships pay each physician chosen $1,000 plus tuition and expenses to Tulane Graduate School of Medicine, and return, and are given by the Commonwealth Fund. Arrangements have also been made for five undergraduate medical scholarships for the sons of physicians and others, these scholarships to pay $100 a month for four years plus tuition, which will easily amount to $1800 during the four years course and making each scholarship worth practically $7,000. This program has been promised for a minimum period of ten years and may be extended to fifteen. These fellowships and scholarships, with $25,000 each year paid to Tulane University to take care of Mississippi graduate and undergraduate scholarships by the Commonwealth Fund will amount to more than a million dollars for medical education in Mississippi during the next ten years.

The following six young men have been awarded scholarships to enter Tulane School of Medicine this Fall: James G. Blaine, Clinton; Edwin M. Meek, West Point; Aubrey V. Beacham, Hattiesburg; Paul Rogers Googe, Booneville; Onie P. Myers, Collinsville, and Russell L. Welch, Norfield.

The undergraduate scholarships and postgraduate fellowships awarded have nothing to do with public health but are simply straight-out medical courses. The men awarded the postgraduate courses will take the subjects most useful to them in their practice. The only purpose the State Board of Health and the Commonwealth Fund have in awarding these fellowships is to be of assistance to the physicians of Mississippi many, of whom are unable to pay for postgraduate courses themselves, and to improve the standards of medical practice in the State.

COMMUNICABLE DISEASES.

The Bureau of Communicable Diseases of the Mississippi State Board of Health reports for the month of June, typhoid fever, 101 cases; smallpox, 143; diphtheria, 22; epidemic cerebrospinal meningitis, 5; pellagra, 2184; tuberculosis, 163. Now is the time to urge and to administer typhoid vaccine, smallpox vaccine, and toxin-antitoxin mixture or toxoid.

HONOR ROLL FOR SEPTEMBER.

The following are contributors to the Mississippi Section this month: C. M. Speck, J. S. Ullman, K. R. Commack, G. S. Bryan, G. H. Wood, E. F. Howard, J. W. Lipscomb, I. E. Stennis, R. P. Donaldon, L. B. Austin, M. L. Montgomery, L. Wallin, E. H. Jones, F. J. Underwood, C. W. Patterson, E. B. Burns, C. M. Coker, D. W. Jones, J. C. Pegues, E. E. Benoist, T. H Rayburn, A. Street, J. A. K. Birchett, Jr., G. C. Jarratt, W. E. Johnson, R. C. Finlay, T. L. Bennett, L. L. Minor, O. N. Arrington, Albert Hand, G. W. Acker, J. N. Rape, J. M. Acker, Jr., W. K. Stowers, R. H. Brumfield, A. H. Little.

Your editors thank you.

MISSISSIPPI STATE BOARD OF HEALTH.

Miss Augustine B. Stoll, R. N., of New York, began work with the Mississippi State Board of Health on July 15. Miss Stoll has had much valuable training and experience. She was on the staff of Bellevue Hospital, New York City, did rural public health nursing in New York, and for several years was Supervisor of Child Welfare Work in Czechoslovakia. She was on the staff of the Mexico Association in charge of Indian Affairs and as a nurse worked with the Indians for four years. Miss Stoll has just completed a postgraduate course in public health nursing at Columbia University and the State Board of Health considers itself fortunate to be able to secure her services.

Dr. J. H. Janney, Director of the Training Station for Health Workers at Indianola, Mississippi since 1928, has been transferred by the Rockefeller Foundation to Maryland. Dr. Chas. A. Bailey, formerly representative of the Foundation at

Paris, France is now in charge of the Training Station.

Dr. Henry Daspit, Dean of the Tulane Graduate School of Medicine, New Orleans, was a visitor at the State Department of Health offices on August 12. Dr. Daspit's visit was for the purpose of discussing details relative to the postgraduate fellowships which have been awarded to fifteen Mississippi physicians under the Commonwealth Fund's plan of co-operation with the State Board of Health.

Prof. Wm. F. Wells of Harvard University, Boston, spent two weeks with the State Board of Health during the month of July. Prof. Wells was especially interested in rural sanitation and malaria control activities of the Mississippi Health Department, and spent most of his time in the Delta with the full-time health departments which have excellent programs along the lines mentioned.

Dr. W. A. Davis, State Registrar of Vital Statistics, Austin, Texas, visited the State Board of Health offices on August 17 for the purpose of studying the new indexing method used by the Mississippi Bureau of Vital Statistics.

Mr. H. R. Fullerton and Mr. M. F. Wooten, Jr., sanitary engineers, Division of Malaria Control of the Tennessee State Board of Health, spent the week of August 17 in the Delta section of Mississippi. Their visit was for the purpose of making observations of the Mississippi State Board of Health malaria control activities with special reference to the program and results accomplished by minor drainage in that section of the State.

Other visitors to the State Board of Health for the purpose of studying and observing health work in Mississippi were as follows: Dr. Frank Bane, State Commissioner of Public Welfare of Virginia; Dr. John E. Monger, Columbus, Ohio; Dr. C. P. Coogle, Malariologist, U. S. Public Health Service, Memphis, Tennessee; Mr. N. M. Cregor, Vice President, Vitamin Food Company, New York, N. Y.; Mr. Herbert Wilson, Washington, D. C.; Dr. Jos. W. Mountin, U. S. Public Health Service, Washington. D. C.; Dr. L. L. Lumsden, Medical Officer, U. S. Public Health Service, Washington, D. C.; Dr. Taliaferro Clark, Representative, Julius Rosenwald Fund, U. S. Public Health Service, Washington, D. C.

A COMMUNICATION.

Dr. Leon S. Lippincott, Secretary

Issaquena-Sharkey-Warren Counties
Medical Society

Vicksburg, Mississippi.

Dear Dr. Lippincott:

Agreeable to my promise to you the other night, I am enclosing a copy of American Medical Association resolution. Under this resolution, Dr. Barrier has not been guilty of over-stepping his bounds for the reason that the physicians within his jurisdiction had a meeting more than a year ago agreed upon the program which he has carried out since that time.

While the resolution passed by the Issaquena-Sharkey-Warren Counties Medical Society at its last meeting is in line with the general policy of the State Board of Health, I feel that if it is published in the New Orleans Medical and Surgical Journal without the American Medical Association's definition of "state medicine" and without an explanation that the physicians within Dr. Barrier's jurisdiction met and agreed upon a plan whereby he was to treat indigent cases of syphilis, that it would be unfair and unjust to the Issaquena-Sharkey Counties Health Officer and to the State Board of Health.

Dr. Benton of Issaquena County and Drs. Goodman and Pool of Sharkey County all stated at the Committee Hearing on August 6 that Dr. Barrier was doing exactly what the local medical group in Sharkey and Issaquena Counties had agreed for him to do and that they had no criticisms to offer.

* * * * *

With best wishes, I am

Very truly yours,

(Signed) Felix J. Underwood.

THE DEFINITION.

" 'State medicine' is hereby defined for the purpose of this resolution to be any form of medical treatment, provided, conducted, controlled, or subsidized by the federal or any state government, or municipality, excepting such service as is provided by the Army, Navy, or Public Health Service, and that which is necessary for the control of communicable disease, the treatment of mental disease, the treatment of the indigent sick, and such other services as may be approved by and administered under the direction of or by a local county medical society of which it is a component part.—Resolution passed by the American Medical Association at its annual meeting in 1922."

BOOK REVIEWS

Text Book of Physical Therapy: By William Benham Snow, M. D. New York, New York Scientific Authors' Publishing Company. 1931. pp. 708.

This book presents an enormous amount of material, and is divided into 3 sections. The first section, "Constant Current and Static Current," has 20 chapters dealing with the application of this kind of current in the treatment of disease.

The second section, "High Frequency Currents," explains the development, physics, physical effects, physiological effects, and the therapeutics of high frequency current in its application in the treatment of many diseases. There are 15 chapters to this section.

The third section, "Electrosurgery," elaborates upon the development and accomplishments of electrosurgery and includes its application to the treatment of diseased tonsils, hemorrhoids, etc. There are 8 chapters in the last section of this book.

According to the text, nearly every known disease is susceptible of treatment by physical therapy.

LEON J. MENVILLE, M. D.

Textbook of Histology: By Eugene C. Piette, M. D. Philadelphia, F. A. Davis Company. 1931. pp. 466.

The reader of this work will be impressed by the compactness of its treatment of histology, and by the manner in which both practical applications of this subject and the correlation of structure and function are introduced. Dr. Piette has sought to make a concise text, and this he has done without injecting the atmosphere of a compend. It is distinctively a *practical* textbook, and it may be noted that the author's association with pathology is of eminent importance in this connection. The typographical arrangement, including headings and bold-faced printing of key words, provides an effectual aid in reading.

HAROLD CUMMINS, Ph. D.

Preparation of Scientific and Technical Papers: By Sam F. Trelease and Emma S. Yule. Baltimore, Williams & Wilkins. 1930. pp. 117.

This handbook, a reprint of the second edition (1927), is a convenient and very valuable guide to the writing of a paper in any field of the exact sciences. Though primarily designed for the use of students, the book will be equally serviceable as a reference book to the professional man who has occasion to do scientific writing.

CHARLES MIDLO, M. D.

Streptococcic Blood Stream Infections: By George E. Rockwell. New York, Macmillan Company. 1931. pp. 73.

In this treatise the author has succeeded in giving a succinct account of the phases of physiology, pathology, chemistry, and bacteriology concerned in streptococcic blood stream infections. The facts derived from these basis sciences are then lucidly applied to explain the rationale of the measures employed in the diagnosis, management, and treatment of the streptococcic blood stream infections.

In an appendix, the intravenous use of mercurochrome, gentian violet, and sodium ricinoleate is critically reviewed.

There is a comprehensive index.

CHARLES MIDLO, M. D.

Introduction to Medical Biometry and Statistics: By Raymond Pearl. 2nd rev. ed. Philadelphia, W. B. Saunders Co. 1930. pp. 459.

A second edition of a book already considered a medical classic. It is of inestimable value to one interested in the quantitative aspects of the medical subjects and statistical studies. Its one unfortunate circumstance is the great amount of mathematics and mathematical formulae necessarily employed but which is *terra incognita* to the majority of physicians.

I. L. ROBBINS, M. D.

Abdomino-Pelvic Diagnosis in Women: By Arthur John Walscheid, M. D. St. Louis, C. V. Mosby Company. 1931. pp. 1000.

In his text Dr. Walscheid steps out of the usual form of texts, and approaches the subject from a different point of view. Part one deals with anatomical considerations, normal and abnormal. The chapter on anthropology, as a rule not considered in texts on gynecology, is fully covered.

The systematic arrangement of a part dealing with general causal factors, pathologic processes, symptoms and diagnosis and the second part dealing with individual organs from the standpoint

of pathology and diagnosis, together with illustrative cases makes it an excellent reference text. It will be observed that only allusions are made to some special treatments but an attempt is made to consider this point of view. There are a good many illustrations to emphasize pathological specimens.

ADOLPH JACOBS, M. D.

The Criminal, the Judge and the Public: By Franz Alexander, M. D., and Hugo Staub. New York, The Macmillan Co. 1931. pp. 238.

The title of this book for review could well be termed "The Mind and the Law." This is written in two parts and translated from the German by a graduate physician, psychoanalysist, and an attorney-at-law.

Apparently very little has been lost in the translation as regards subject matter. For the most part it is in an entirely psychoanalytic vein with interpretations, explanations and descriptions in keeping with psychoanalysis. It is decidedly socio-medico-legal in context. The criminalistic tendencies in the normal and the criminal are microscopically examined. There is much concerning the application of justice to these cases and the methods, means and manner by which they may be approached. The question of sexual psychopathy is entered into (the examiner thinks this a more scientific term to use), with great detail and should be instructive to the lawyer as well as those heading social problems.

Then follows a description of celebrated cases in which psychoanalysis was used to aid them in their difficulties and then follows psychology of punishment. This is replete with psychoanalytic explanations.

Psychiatrists, alienists should do well to read this. It should likwise make substantial collateral reading for child guidance directors and mentally equipped social workers.

The question of analysis of the subject, in the examiner's opinion, should only be done by a graduate, qualified physician, preferably in all instances a psychiatrist.

WALTER J. OTIS, M. D.

The Infant Welfare Movement in the Eighteenth Century: By Ernest Caulfield, M. S., M. D., with a Foreword by Dr. G. F. Still. New York, Paul B. Hoeber, Inc. 1931. pp. 203.

This is a well written volume, in narrative form, which covers the important events of the infant welfare movement in London during the eighteenth century.

The book is particularly interesting, due primarily to the fact that it covers the peak in the dark ages of pediatrics and the descent of enlightenment begins. The manifest indifference, cruelty and unconcern towards children, as revealed by this story, is barely believable, even though the time was two hundred years ago. Casting off the shackles of such an attitude that was due to ignorance required the concerted action of great men. The call was ably answered by such men as Coram, Cadogan, Hanway and Armstrong.

I can heartily recommend this book to any one interested in the evolution that has taken place, or should we say the *revolution* that took place in eighteenth century pediatrics of London. It would be a valuable book to any one making a comparative study of the transition that has come about in infant welfare work.

C. T. WILLIAMS, M. D.

Eye, Ear, Nose and Throat for Nurses: By Jay G. Roberts, Ph. G., M. D., F. A. C. S. Philadelphia, F. A. Davis Co. 1931. pp. 213.

This is a useful little book for the nurse to refer to for general information about the eye, ear, nose and throat. The illustrations are valuable for familiarizing the nurse with instruments used in this surgical specialty.

The author advises the use of chloroform anesthesia for tracheotomy in children. This is at variance with the general opinion which demands local anesthesia in *any* patient so dyspneic as to be using his accessory (voluntary) muscles of respiration. Obviously, if these are paralyzed by a general anesthetic the result is disastrous.

H. KEARNEY, M. D.

Manual of Surgery: By Alexander Miles, M. D., LL. D., F. R. C. S., Ed., and D. P. D. Wilkie, M. D., F. R. C. S., Ed. and Eng. V. 1. 8th ed. London, Oxford Univ. Press. 1931. pp. 574.

The eighth edition of this book, comprising over five hundred pages of reading matter and one hundred seventy-six illustrations, besides presenting the present day status of surgery, reflects the teaching of the Edinburgh School.

Twenty-one collaborators, each dealing with subjects in which they are specially interested, have contributed to this manual.

This book is not only valuable for the student, but makes a ready reference for the busy practitioner.

PAUL G. LACROIX, M. D.

An Introduction to Gynecology: By C. Jeff Miller, M. D. St. Louis, The C. V. Mosby Company. 1931. 117 illust. pp. 327.

Here is a scholarly exposition of the fundamentals of gynecology. Intended for beginning students, the book does not consider therapy. The author arranges the subject matter in sixteen chapters to conform with the sixteen week course in junior gynecology at the Tulane School of Medicine. A concise section on the anatomy and physiology of the pelvic structures is followed by a very valuable consideration of the endocrine glands in relation to gynecology. The author then deals with the methods of examination and diagnosis. Three chapters are devoted to inflammatory conditions, and one chapter each to obstetric injuries and malpositions of the uterus. Tumors are discussed in five chapters and the last three sections are devoted to functional disorders: dysmenorrhea, sterility, irregularities of the menstrual flow, and ectopic pregnancy.

The book is splendidly written. It needs must be read. Each paragraph fairly bristles with facts, and, furthermore, each statement carries within itself the parenchyma of convincement fostered by twenty-five years of close clinical observation and study.

It is a pity that some of the figures selected to illustrate the subject matter are not worthy of the text they accompany. That, however, is a minor fault which need not deter the student from reading this masterly compilation of the essentials of gynecology.

CHARLES MIDLO, M. D.

Lehrbuch und Atlas der Spaltlampenmikroskopie des Lebenden Auges: Text Book and Atlas of Slit-Light Microscopy of the Living Eye: Alfred Vogt. 2nd Ed. Vol, 1, Technique and Methods, Cornea and Anterior Chamber. 632 illus. Berlin, Julius Springer. 1931. pp. 313.

While reviewing this and other recent German ophthalmic books, a rather odd thought has repeatedly occurred to me. The Germans are apparently trying hard to make theirs' the world's scientific written language, at least in ophthalmology. Furthermore, they are apparently forcing a new type of book on those who keep pace with international ophthalmic progress, and at an almost prohibitive price. For example, this is one of a three volume series, costing, approximately, $50 per volume. Several other recent volumes have appeared at prices ranging from $35 to $65 per volume. Needless to add, these books are not published in other languages. The thoroughness of the text, the completeness of the bibliography, and the remarkable quantity and quality of illustrations make these volumes indispensible, however, to the German reading ophthalmologist, even though the cost is plainly exorbitant.

This second edition in three volumes is written around the first one volume edition which appeared some ten years ago.

The principles and construction of the Zeiss lamp are very clearly and minutely explained. Naturally, we Americans feel that our Bausch & Lomb instrument, which is equally as good, should have been also described. The methods and technic, including various forms of illumination and observation, as well as the objective findings most frequently encountered, are then discussed in some thirty-five pages.

The normal cornea with especial reference to its anatomic details as seen with the slit lamp,

is described and pictured in a most detailed and artistic manner, as are senile changes and the various degenerations.

The anterior ocular findings associated with pseudo sclerosis as presented, are both new and interesting.

Almost one hundred pages and two hundred illustrations are devoted to inflammatory corneal affections as seen with the slit light.

Injuries, non traumatic tears of Descemet's membrane, also folds, blood staining, and affections of undetermined origin are then discussed.

Lastly, the anterior chamber is described with its various affections.

The literature references, numbering about two hundred and fifty, are quite well arranged, as is the excellent index and table of contents.

To the ophthalmologist who reads German, this outstanding volume with its remarkable illustrations, is of great service in the better understanding of slit-light microscopy which has changed so many of our conceptions in ocular pathology.

CHAS. A. BAHN, M. D.

A Clinical Study of Addison's Disease: By Leon G. Rowntree, M. D., and Albert M. Snell, M. D. Philadelphia, W. B. Saunders Company. 1931. pp. 317.

This study of Addison's disease should be read by all physicians and students interested in this disease. One of the many commend able features of this little book is the original description of the disease by Addison in 1855, a most inspiring article. The pathologic physiology of the suprarenal glands in Addison's disease is clearly presented, and clinical records of 65 cases described.

Perhaps of greatest importance to the practitioner is the section on treatment. We are all familiar with the Muirhead treatment, which was the most efficient method up to the time of the preparation of an aqueous extract of the suprarenal cortex by Swingle and Pfiffner in March, 1930. Rowntree and Snell give the records of nine cases treated with this new extract which is not yet on the market. While the authors are rightly modest in regard to results obtained by the use of this extract, it would appear that another very important discovery had been made in substitution therapy, one comparable to insulin in diabetes, except that the Addisonian patient generally has a tuberculous condition to contend with as well as a lack of cortical hormone. Nevertheless, if he can be tided over his exacerbations by this extract, his chance against the tuberculous infection is greatly enhanced. It is devoutly to be hoped that the long awaited cortical hormone is at hand.

RANDOLPH LYONS, M. D.

PUBLICATIONS RECEIVED.

Oxford University Press, New York: Diseases of the Gums and Oral Mucous Membrane, by Sir Kenneth Goadby, K. B. E., M. R. C. S., L. R. C. P., D. P. H., Fourth Edition. Encephalitis Lethargica Its Sequelae and Treatment, by Constantin von Economo. The Causation of Chronic Gastro-Duodenal Ulcers a New Theory, by J. Jacques Spira, M. R. C. S., L. R. C. P. (Lond.).

P. Blakiston's Son & Co., Inc., Philadelphia Medical Jurisprudence, by Carl Scheffel, Ph. B., M. D., LL.B. Gould's Medical Dictionary, by George M. Gould, A. M., M. D.

The Midwest Company, Minneapolis: What the Public Should Know About Childbirth, by Walter Bourne Gossett, M. D.

Thacker, Spink & Co., Calcutta: Indian Medical Research Memories, by R. Knowles, I. M. S.

Thacker's Press & Directories, Ltd., Calcutta: Calcutta School of Tropical Medicine and Hygiene for the Year 1930, Appendix B., Calcutta School of Tropical Medicine and Hygiene for the Year 1930, Appendix A.

Bengal Government Press, Calcutta: Annual Report of the Calcutta School of Tropical Medicine Institute of Hygiene and the Carmichael Hospital for Tropical Diseases, 1930.

The Century Co., New York: Pediatric Education.

Librairie Felix Alcan, Paris: Centrotherapie et Asuerotherapie, by Mme. E. Pierre Bonnier, M. D.